

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G263 5/11/60 iwk

04069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Res. 1318 Eye St. S.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Little Pertuxent River		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Curtis Leo Allen		4. DATE OF DEATH Month Day Year Found dead April 30th. 19 60	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/22/51
9. AGE (In years last birthday) 8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Washington D.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roscoe Allen		14. MOTHER'S MAIDEN NAME Mamie Hackett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Cjildren's Center Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental retardation			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was found drowned in the little Pertuxent River.	
20c. TIME OF INJURY Month, Day, Year Unknown. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Little Pertuxent River, Laurel, A.A.		20f. (City or town) (County) (State) Maryland.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Joyner		ADDRESS 116 Maple Ave. Wash D.C.	
24a. REC'D BY REGISTRAR MAY 6 '60		24b. REGISTRAR'S SIGNATURE Charles E. Kenna	

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland				c. LENGTH OF STAY IN 1b 11/3/33			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School, Children's Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Allen Last Allen				4. DATE OF DEATH Month April Day 13 Year 1960			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1930		9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months 29 Days 13 Hours 19 Min. 60	IF UNDER 24 HRS. Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver Allen				14. MOTHER'S MAIDEN NAME Louise Edwards			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) --		INFORMANT District Training School, Children's Center, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART DISEASE 758.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MARFAN'S SYNDROME DUE TO (c) 3 months							INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Retardation							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --	20f. (City or town) --	(County) --	(State) --		
21. I certify that I attended the deceased from October 54 , 19 54 , to April 13 , 19 60 , that I last saw the deceased alive on 4/13/60 , 19 60 , and that death occurred at 12:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Officer, Children's Center, Laurel, Md. DATE SIGNED 4/13/60							
ACTUAL SIGNATURE Margaret Wong Mola		M.D. Medical Officer, Children's Center, Laurel, Md.					
PHYSICIAN'S NAME (Type) Margaret Wong Mola, M.D.		" " " "					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 15, 1960	22c. NAME OF CEMETERY OR CREMATORY District Training School		22d. LOCATION (City, town, or county) Laurel, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Delister		ADDRESS District Training School		24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE Anthony L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

758.6

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4168 CERTIFICATE OF DEATH

64071

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN lb 13 years 4mo. 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1909 N. Fulton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cas Middle Alston Last Alston				4. DATE OF DEATH Month 4 Day 26 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 15, 1910	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 4 Days 26		IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Al Alston				14. MOTHER'S MAIDEN NAME Minerva			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Cardiovascular Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year 19 Hour 4 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 12/13 1946 to 4/26 1960 , that (I) (we) last saw the deceased alive on 4/26 1960 , and that death occurred at 8:45 A. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 4/26/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/30/60		23c. NAME OF CEMETERY OR CREMATORY Arboretus Memorial Park		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Charles G. Cooper				ADDRESS 510 Carrollton Ave		25a. REC'D BY REGISTRAR DATE MAY 6 '60	
				25b. REGISTRAR'S SIGNATURE Clifton S. Kraus			

1901

1168



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64072

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 12 yrs. 6mo. 19days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01, 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1819 Vine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Last Artis				4. DATE OF DEATH Month 4 Day 30 Year 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1901	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard Flowers				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Capillary Glomerulosclerosis DUE TO (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/5 11:10 to 4/30 19 60 , that (I) (we) last saw the deceased alive on 4/30 19 60 , and that death occurred at P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 5/2/60	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/5/60		23c. NAME OF CEMETERY OR CREMATOR Balto. National		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Mrs. Talitha H. Williams				25a. REC'D BY REGISTRAR DATE MAY 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

b4073
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solly, P.O. Glen Burnie</u> c. LENGTH OF STAY IN lb <u>15 days ?</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In the woods, off Fort Smallwood Rd. Pennington and Filbert Streets</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3 V01.4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond Eldridge Baldwin</u>				4. DATE OF DEATH <u>Found dead</u> <u>April 15</u> Day Year <u>19 60</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/28/08</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Acetylene Burner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Patapsco Scrap</u>				11. BIRTHPLACE (State or foreign country) <u>Prince George County</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel Baldwin</u>						14. MOTHER'S MAIDEN NAME <u>Sarah E. Jones</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-05-4087</u>				17. INFORMANT Address <u>Mrs. Ruth Baldwin, Wife, HighPoint, Pasadena, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self inflicted wound to the head with a 12</u> <u>976 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>gauge double barrell shot gun.</u> (c) <u>Sudden</u> DUE TO (a), stating the underlying cause last.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>See #18</u>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Unknown</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Off Fort Smallwood Rd. Solly, Glen Burnie, AA Md.</u>				20f. (City or town) (County) (State) <u>AA Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>						DATE SIGNED <u>4/15/60</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/16/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>				22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>						24a. REC'D BY REGISTRAR <u>APR 18 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in writing. This certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9762

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4171

CERTIFICATE OF DEATH

Reg. Dist. No. 64074

1. PLACE OF DEATH a. COUNTY <u>H.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PL. PLEASANT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PL. PLEASANT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TERACE J.</u>		d. STREET ADDRESS <u>TERACE J.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elfreda</u> Middle <u>BAUSTIAN</u> Last <u>BAUSTIAN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-95</u>
9. AGE (in years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>PA.</u>	
13. FATHER'S NAME <u>Charles Jay</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Belle Debus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family</u>	
17. INFORMANT <u>Family</u>		Address <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephrosclerosis</u> DUE TO <u>2</u> (c) <u>Hypertensive C.V.D.</u> DUE TO <u>2</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1500</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>60</u> , to <u>4-7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-7</u> , 19 <u>60</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1101 Park Road</u> DATE SIGNED <u>April 12 1960</u>			
ACTUAL SIGNATURE <u>Henry S. [Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>Bedford [Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-11-60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Green [Signature]</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClary - 130 E. [Signature]</u> ADDRESS <u>130 E. [Signature]</u>		24a. REC'D BY REGISTRAR <u>APR 12 1960</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

443 X

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death	
6. Place of birth		7. Usual residence		8. Cause of death		9. Manner of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of medical examiner		14. Signature of coroner		15. Signature of funeral director	
16. Signature of health officer		17. Signature of county health officer		18. Signature of city health officer		19. Signature of town health officer		20. Signature of village health officer	
21. Signature of school health officer		22. Signature of public health nurse		23. Signature of health visitor		24. Signature of health officer		25. Signature of health officer	
26. Signature of health officer		27. Signature of health officer		28. Signature of health officer		29. Signature of health officer		30. Signature of health officer	
31. Signature of health officer		32. Signature of health officer		33. Signature of health officer		34. Signature of health officer		35. Signature of health officer	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4172 CERTIFICATE OF DEATH 64075

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 1910 Cedric Road	
3. NAME OF DECEASED (Type or print) First Charles Middle Beckham Last Beckham		4. DATE OF DEATH Month April Day 18 Year 1960	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabin Stewart		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Beckham		14. MOTHER'S MAIDEN NAME Sally	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 325-30-5162	
17. INFORMANT Medical Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolia of Pulmonary Artery 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Syphilis and Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from 3/29 to 4/18 , that (I) (we) lost saw the deceased alive on 4/18 19 60 , and that death occurred at 1:45 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissmann		22b. DATE SIGNED 4/19/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/21/60	
23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY		23d. LOCATION (City, town, or county) (State) A. A. County Md	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph B. Rock		25a. REC'D BY REGISTRAR APR 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

IX 50

FUNERAL DIRECTOR

510

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1

4173

CERTIFICATE OF DEATH

64076

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN TB 9mo. 44 yrs 10 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		First George		Middle Bedford		Last Bedford		4. DATE OF DEATH Month 4 Day 19 Year 1960	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1880		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) -----								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ----- ----- 15		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----	
20g. (State) -----		21. I certify that (I) (this hospital) attended the deceased from 7/9 1915 , to 4/19 1960 , that (I) (we) lost saw the deceased alive on 4/19 1960 , and that death occurred at 8:15 A. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				M.D. Hildegard Heard Reissman, M. D.		22b. ADDRESS Crownsville State Hospital, Md.		22c. DATE 4/19/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) april 29 1960 University of Maryland		23b. DATE THEREOF april 29 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore Md.		23d. LOCATION (City, town, or county) Baltimore Md.		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Keese				ADDRESS 4110 1st St		25a. REC'D BY REGISTRAR DATE APR 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	

8500

MINISTRY OF HEALTH

1133



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4174

CERTIFICATE OF DEATH

64077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>a a</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>59</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK FREDERICK BENNING</u>				4. DATE OF DEATH Month Day Year <u>April 5 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 21</u>	
9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>sea food</u>		11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>KARL BENNING</u>				14. MOTHER'S MAIDEN NAME <u>Louise Witt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1918</u>				16. SOCIAL SECURITY NO. <u>220303218</u>		17. INFORMANT Address <u>AGNES MAE BENNING</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan.</u> 19 <u>60</u> , to <u>April 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 15</u> , 19 <u>60</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Shady Side, Md. 4/9/60</u>			
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>200 KER</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>				ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4175 CERTIFICATE OF DEATH

64078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundle MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Maryland				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 330 Ordnance Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle W. Last Brooks				4. DATE OF DEATH Month 4- Day 6- Year 19 60			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1874	9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Anne Arundle County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Brooks				14. MOTHER'S MAIDEN NAME Melvina H. Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address I. B. Grinage 700 Whitmore Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 10, 1959 to April 5, 1960 , that I last saw the deceased alive on April 5, 1960 , and that death occurred at 7 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE P. J. Grimaldi M.D.			ADDRESS (Street, city or town, state) 4609 Gov. Ritchie Highway Baltimore 25 Md.				
PHYSICIAN'S NAME (Type) P. J. GRIMALDI			DATE SIGNED Baltimore 25 AAG Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-60		22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Clay O. Wilson				ADDRESS 1000 Cranley Ave		24a. REC'D BY REGISTRAR DATE APR 12 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME
DATE
PLACE
CITY
STATE
COUNTRY

JOHN BROWN

MECHANIC

CERTIFICATE OF DEATH

ARMY AND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Page 100-100

1. Name of deceased		JOHN BROWN	
2. Sex		Male	
3. Age		35	
4. Date of death		1918	
5. Place of death		New York City	
6. Cause of death		Pneumonia	
7. Duration of illness		10 days	
8. Name of physician		Dr. J. H. Smith	
9. Name of informant		John Brown	
10. Signature of informant		[Signature]	
11. Signature of physician		[Signature]	
12. Signature of registrar		[Signature]	
13. Date of registration		1918	
14. Name of registrar		[Name]	
15. Name of registrar		[Name]	
16. Name of registrar		[Name]	
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98. Name of registrar		[Name]	
99. Name of registrar		[Name]	
100. Name of registrar		[Name]	

4176 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3241 4th St.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn</u>	
f. STREET ADDRESS <u>5241 4th St</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES E BROWN</u>		4. DATE OF DEATH Month Day Year <u>April 28 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21-1896</u>
9. AGE (In years, last birthday) <u>63</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bld.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Brown</u>		14. MOTHER'S MAIDEN NAME <u>Alice Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louise R. Brown</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LUNG</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>60</u> , to <u>4/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/28</u> , 19 <u>60</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5010A Killebrew Rd</u> DATE SIGNED <u>4/28/60</u>			
ACTUAL SIGNATURE <u>Benjamin Berdamm</u> M.D.		PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDANN</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-30-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belair Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Riches Highway A.A. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u> ADDRESS <u>Cinnapi Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...the ... of ...

4129

CERTIFICATE OF DEATH

64080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret THOMAS BROWN</u>				4. DATE OF DEATH Month Day Year <u>April 26 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-13-1906</u>	9. AGE (In years last birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS-Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solomon P. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>ELLA Kimble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-14-6708</u>		17. INFORMANT Address <u>ELLA-Parker-81 Northwest ST. ANNAPOLIS-Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/26</u> , 19 <u>60</u> , to <u>4/26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/26</u> , 19 <u>60</u> , and that death occurred at <u>9:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u>				ADDRESS (Street, city or town, state) <u>71 Franklin St.,</u>		DATE SIGNED <u>4/27/60</u>	
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Apr 29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis-Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u>				ADDRESS <u>ANNAPOLIS-Md.</u>		24a. REC'D BY REGISTRAR <u>May 2 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Richard S. K...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-11-1920

CERTIFICATE OF DEATH

1121

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE OF DEATH		DATE OF DEATH	
HOME		11-11-1920	
MARRIED		MARRIED	
SEX OF DECEASED		AGE OF DECEASED	
MALE		35	
RACE OF DECEASED		COLOR OF DECEASED	
WHITE		WHITE	
EDUCATION OF DECEASED		OCCUPATION OF DECEASED	
HIGH SCHOOL		LABORER	
RELIGION OF DECEASED		CAUSE OF DEATH	
METHODIST		HEART DISEASE	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF DEATH	
11-11-1920		11-11-1920	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
TEMPERATURE OF DECEASED		PULSE OF DECEASED	
100.0		60	
BLOOD PRESSURE OF DECEASED		RESPIRATIONS OF DECEASED	
120/80		20	
WEIGHT OF DECEASED		HEIGHT OF DECEASED	
150 LBS		5 FT 10 IN	
HAIR OF DECEASED		EYES OF DECEASED	
BROWN		BLUE	
MOUTH OF DECEASED		NOSE OF DECEASED	
NORMAL		NORMAL	
TEETH OF DECEASED		SKIN OF DECEASED	
GOOD		FAIR	
FINGER NAILS OF DECEASED		TOE NAILS OF DECEASED	
GOOD		GOOD	
HAIR OF DECEASED		EYES OF DECEASED	
BROWN		BLUE	
MOUTH OF DECEASED		NOSE OF DECEASED	
NORMAL		NORMAL	
TEETH OF DECEASED		SKIN OF DECEASED	
GOOD		FAIR	
FINGER NAILS OF DECEASED		TOE NAILS OF DECEASED	
GOOD		GOOD	

Thomas

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14081

1. PLACE OF DEATH o. COUNTY <u>415 Forest View Rd</u> <u>Southem Heights, Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southem Heights</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>Ann</u> Last <u>Buckingham</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Burr Tomlinson</u>		14. MOTHER'S MAIDEN NAME <u>Martha Reed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>7111</u>	
17. INFORMANT <u>Mrs. Martha Bander</u>		Address <u>415 Forest View Rd</u> <u>Southem Hts. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Intestine</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Star</u> c) <u>Star</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic valvular disease of the heart</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>April 13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>60</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Bellonghe</u> M.D.		ADDRESS (Street, city or town, state) <u>108 Cedar Ave Glen Burnie Md</u> DATE SIGNED <u>April 13, 1960</u>	
PHYSICIAN'S NAME (Type) <u>James S. Bellonghe</u>		<u>108 Cedar Ave Glen Burnie Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	22d. LOCATION (City, town, or county) (State) <u>Dorsey, A.A. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F.D. 4101 Edmondson Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

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4178 Items 8 & 9 Film 2261 4/29/60 iwk

64082

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Maryland c. LENGTH OF STAY IN 1b 8 yrs. 10 mo. 10 days. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Bullock Last Bullock		4. DATE OF DEATH Month April Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1903 1898
9. AGE (In years, months, and days) 62 yrs. 5 mos. 18 days		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Bullock		14. MOTHER'S MAIDEN NAME Betsy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Medical Records		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilitic Cardiovascular Disease DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour — min. — p. m. — 19 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that (I) (this hospital) attended the deceased from 3/17 8:45 53 4 to 4/19 19 60 , that (I) (we) last saw the deceased alive on 4/19 19 60 , and that death occurred at — M, from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE 4/19/60	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-25-1960	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery	23d. LOCATION (City, town, or county) (State) Suitland, Maryland.
24. FUNERAL DIRECTOR'S SIGNATURE Wolman & Bohig		25a. REC'D BY REGISTRAR APR 25 60	
ADDRESS 424 R St. N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. Munn	

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11-11-68

CERTIFICATE OF DEATH

11-11-68

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ALICE B. WATKINS

WATKINS, ALICE B.

11-11-68

ALICE B. WATKINS

WATKINS, ALICE B.

ALICE B. WATKINS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
Baltimore, 18

4179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44083

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooksville</u>		c. LENGTH OF STAY IN 1b <u>all life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Anne's</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stephan Rd. Box 72</u>				e. STREET ADDRESS <u>Stephan Rd. Box 72</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN COLIVER BURNETT</u>				4. DATE OF DEATH <u>April 14</u> Month <u>14</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/59</u>		9. AGE (In years last birthday) <u>13</u> yrs. <u>13</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Haskell Burnett</u>				14. MOTHER'S MAIDEN NAME <u>Norma Jean Deas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. N. H. Burnett (mother)</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Infection</u> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eustace H. Baucher MD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Eustace H. Baucher MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>13 April 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Ceme.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10-10-63

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4134



527.2

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. EDUCATION [Illegible]	
9. PRESENT ADDRESS [Illegible]		10. DATE OF DEATH [Illegible]	
11. CAUSE OF DEATH [Illegible]		12. MANNER OF DEATH [Illegible]	
13. SIGNATURE OF MEDICAL EXAMINER [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF DECEASED [Illegible]		16. SIGNATURE OF NEXT OF KIN [Illegible]	
17. SIGNATURE OF CLERK [Illegible]		18. SIGNATURE OF JURY [Illegible]	
19. SIGNATURE OF JURY [Illegible]		20. SIGNATURE OF JURY [Illegible]	
21. SIGNATURE OF JURY [Illegible]		22. SIGNATURE OF JURY [Illegible]	
23. SIGNATURE OF JURY [Illegible]		24. SIGNATURE OF JURY [Illegible]	
25. SIGNATURE OF JURY [Illegible]		26. SIGNATURE OF JURY [Illegible]	
27. SIGNATURE OF JURY [Illegible]		28. SIGNATURE OF JURY [Illegible]	
29. SIGNATURE OF JURY [Illegible]		30. SIGNATURE OF JURY [Illegible]	
31. SIGNATURE OF JURY [Illegible]		32. SIGNATURE OF JURY [Illegible]	
33. SIGNATURE OF JURY [Illegible]		34. SIGNATURE OF JURY [Illegible]	
35. SIGNATURE OF JURY [Illegible]		36. SIGNATURE OF JURY [Illegible]	
37. SIGNATURE OF JURY [Illegible]		38. SIGNATURE OF JURY [Illegible]	
39. SIGNATURE OF JURY [Illegible]		40. SIGNATURE OF JURY [Illegible]	
41. SIGNATURE OF JURY [Illegible]		42. SIGNATURE OF JURY [Illegible]	
43. SIGNATURE OF JURY [Illegible]		44. SIGNATURE OF JURY [Illegible]	
45. SIGNATURE OF JURY [Illegible]		46. SIGNATURE OF JURY [Illegible]	
47. SIGNATURE OF JURY [Illegible]		48. SIGNATURE OF JURY [Illegible]	
49. SIGNATURE OF JURY [Illegible]		50. SIGNATURE OF JURY [Illegible]	
51. SIGNATURE OF JURY [Illegible]		52. SIGNATURE OF JURY [Illegible]	
53. SIGNATURE OF JURY [Illegible]		54. SIGNATURE OF JURY [Illegible]	
55. SIGNATURE OF JURY [Illegible]		56. SIGNATURE OF JURY [Illegible]	
57. SIGNATURE OF JURY [Illegible]		58. SIGNATURE OF JURY [Illegible]	
59. SIGNATURE OF JURY [Illegible]		60. SIGNATURE OF JURY [Illegible]	
61. SIGNATURE OF JURY [Illegible]		62. SIGNATURE OF JURY [Illegible]	
63. SIGNATURE OF JURY [Illegible]		64. SIGNATURE OF JURY [Illegible]	
65. SIGNATURE OF JURY [Illegible]		66. SIGNATURE OF JURY [Illegible]	
67. SIGNATURE OF JURY [Illegible]		68. SIGNATURE OF JURY [Illegible]	
69. SIGNATURE OF JURY [Illegible]		70. SIGNATURE OF JURY [Illegible]	
71. SIGNATURE OF JURY [Illegible]		72. SIGNATURE OF JURY [Illegible]	
73. SIGNATURE OF JURY [Illegible]		74. SIGNATURE OF JURY [Illegible]	
75. SIGNATURE OF JURY [Illegible]		76. SIGNATURE OF JURY [Illegible]	
77. SIGNATURE OF JURY [Illegible]		78. SIGNATURE OF JURY [Illegible]	
79. SIGNATURE OF JURY [Illegible]		80. SIGNATURE OF JURY [Illegible]	
81. SIGNATURE OF JURY [Illegible]		82. SIGNATURE OF JURY [Illegible]	
83. SIGNATURE OF JURY [Illegible]		84. SIGNATURE OF JURY [Illegible]	
85. SIGNATURE OF JURY [Illegible]		86. SIGNATURE OF JURY [Illegible]	
87. SIGNATURE OF JURY [Illegible]		88. SIGNATURE OF JURY [Illegible]	
89. SIGNATURE OF JURY [Illegible]		90. SIGNATURE OF JURY [Illegible]	
91. SIGNATURE OF JURY [Illegible]		92. SIGNATURE OF JURY [Illegible]	
93. SIGNATURE OF JURY [Illegible]		94. SIGNATURE OF JURY [Illegible]	
95. SIGNATURE OF JURY [Illegible]		96. SIGNATURE OF JURY [Illegible]	
97. SIGNATURE OF JURY [Illegible]		98. SIGNATURE OF JURY [Illegible]	
99. SIGNATURE OF JURY [Illegible]		100. SIGNATURE OF JURY [Illegible]	

CERTIFICATE OF DEATH

64084

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENOCK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENOCK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MYRTLE M CATHERTON</u>		4. DATE OF DEATH Month Day Year <u>April 20 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>GREENOCK MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benjamin Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Phipps</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Vincent Catherton Bristol, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-25</u> , 19 <u>60</u> , to <u>4-2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emil H. Lubin</u>		DATE SIGNED <u>4-22-60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Lothung MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
ADDRESS <u>Salisbury</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AN. CO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>824 Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>E.</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-42</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>18</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Ft. Meade, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Joseph Kinsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-40-2816</u>	
17. INFORMANT <u>Thomas E. Campbell</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inhalation of Carbon Monoxide</u> DUE TO <u>Car by trying to check tyre</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> DUE TO <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Truck ran over on subject</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-10-60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Adels MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 Apr. 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. D. Singleton</u>		ADDRESS <u>Glen Burnie, MD.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>APR 13 '60</u>			

DATE SIGNED 4-10-60

4131 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>5 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				/d. STREET ADDRESS <u>Box-285</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DRUSILLA</u> Middle <u>ANNE</u> Last <u>CAUDLE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1960</u>	
9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>05</u>		IF UNDER 24 HRS. Days <u>05</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Mervin Braxton CAUDLE</u>				14. MOTHER'S MAIDEN NAME <u>Bertamae Irene WHITING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pre-Natal Anoxia</u> DUE TO (c) <u>Pre-Natal Anoxia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Apr. 26, 1960</u> , to <u>Apr. 26, 1960</u> , that I last saw the deceased alive on <u>Apr. 26, 1960</u> , and that death occurred at <u>10:05A</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton Norton</u>				M.D. <u>Medical Building</u> DATE SIGNED <u>10:05A</u>			
PHYSICIAN'S NAME (Type) <u>Clayton Norton</u>				<u>Severna Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-2-1960</u>		<u>Private Cem</u>		<u>Annapolis Neeb Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Fay</u>				ADDRESS <u>Severna Park, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 16

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		1. d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Mary Rebecca Chisley</u>		4. DATE OF DEATH <u>Month Day Year</u> <u>Apr 12 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lloyd Toney</u>		14. MOTHER'S MAIDEN NAME <u>Martha James</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mammie Turner</u>		Address <u>Odenton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1946</u> to <u>Apr 11 12, 1960</u> , that I last saw the deceased alive on <u>Mar 28 1960</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward G. Skerritt</u> M.D. <u>6/26/60</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4-12-60</u>	
PHYSICIAN'S NAME (Type) <u>Edward G. Skerritt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-16-60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Odenton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold A. Johnson</u> ADDRESS <u>Arnold A. Johnson</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 18 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Thelma Avenue		d. STREET ADDRESS Thelma Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jesse Middle William Last Cogle		4. DATE OF DEATH Month April Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1890
9. AGE (In years lost birthday) yrs. 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jonathan Cogle		14. MOTHER'S MAIDEN NAME Lucy Derry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Maude Cogle Address Same as 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO (b) BRONCOGENIC CARCINOMA Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 2 da. 2 YRS.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from 10-5 , 19 54 to 4-21 , 19 60 , that I last saw the deceased alive on 4-18 , 19 60 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-22-60 ACTUAL SIGNATURE Leon C. Perry M.D. PHYSICIAN'S NAME (Type) Leon Perry, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 25 Apr., 60	
22c. NAME OF CEMETERY OR CREMATORY Harpers Cemetery		22d. LOCATION (City, town, or county) (State) Harpers Ferry, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE APR 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4132 **CERTIFICATE OF DEATH**

64089

Item 12 Film 0261 4-20-60 et

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 33 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lottie Middle COLE Last COLE		4. DATE OF DEATH Month April Day 11 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1874
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 33 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Canada, TORONTO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Gibbs		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Olive M. Shoemaker, Shadyside Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Gangrene of rt. leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis of popliteal artery (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic ht. disease & coronary insufficiency			
INTERVAL BETWEEN ONSET AND DEATH 3 weeks 33 days years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 9, 1960 to April 11, 1960 , that (I) (we) last saw the deceased alive on April 11, 1960 , and that death occurred at 2:36 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Willard F. Smith		22b. DATE SIGNED 4/12/60	
22c. PHYSICIAN'S NAME (Type) Willard Smith		22d. ADDRESS Shadyside, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/60	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Bladensburg Md	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty		25a. REC'D BY REGISTRAR Holmesville Md	
25b. REGISTRAR'S SIGNATURE Chibing S. Hwang		DATE APR 14 '60	

450.1

4133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64092

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>47X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Cox</u> Last <u>Cox</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>BSL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Enoch Cox</u>		14. MOTHER'S MAIDEN NAME <u>Ida Shepherd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Sara R. Cox</u>		Address <u>1410 Euclid Street, N.W. #7</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Fell overboard from boat while boating</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:30</u> <u>4</u> <u>17</u> <u>19</u> <u>60</u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back Creek</u>		20f. (City or town) (County) (State) <u>Eastport, Annapolis AA Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Borssuck</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>acting.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Fisher</u> W. Ernest Jarvis Co., Inc. 1432 You St., N.W.		24a. REC'D BY REGISTRAR <u>APR 22 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		DATE <u>4/17/60</u>	

MEDICAL CERTIFICATION

02

2

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M

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

64093

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4182 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 2 mo. 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Marie Davis				4. DATE OF DEATH Month Day Year 4 13 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1899	
9. AGE (In years lost birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min. 3 0 1 4		11. IF UNDER 24 HRS. Months Days Hours Min. 3 0 1 4		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Septicemia, decubital Ulcers Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) 053,4 DUE TO (c) since adm.						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Hypertensive Cardiovascular Disease, Right Hemiparesis, Fracture of Femur							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour m - p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 2/4 19 60 to 4/13 19 60 that (I) (we) lost saw the deceased alive on 4/13 19 60 , and that death occurred at 3:30 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman M.D.				22b. DATE 4/13/60		22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-18-1960		23c. NAME OF CEMETERY OR CREMATORY Arboretum Mem. Baltimore Co. Md.		23d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William J. Smith				25a. REC'D BY REGISTRAR APR 19 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

01003

CERTIFICATE OF DEATH

1122

4530

1

CHIEF OF POLICE

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through from the reverse side of the page.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4183 CERTIFICATE OF DEATH

64095

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 13 years 11mo. 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 509 Orchard Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Duppins				4. DATE OF DEATH Month Day Year 4 30 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1874	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Syphilitic Cardiovascular Disease DUE TO (c) General Paresis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 5/17 11:05 to 4/30 1960 , that (I) (we) last saw the deceased alive on 4/30 1960 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/2/60	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) 5/5/60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY mt Auburn		23d. LOCATION (City, town, or county) (State) Baltimore city md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS 575 W. Biddle		25a. REC'D BY REGISTRAR May 4 '60	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

4183
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____
12. Place of registration: _____

RECEIVED
MAY 10 1918
MORTUARY

4134 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>Tracy's</u>			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Nicholas</u> Last <u>Easton</u>				4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 3 1898</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alfred Easton</u>				14. MOTHER'S MAIDEN NAME <u>Annie Bonnet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Richard Easton, Tracy's, Co. Co.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension and generalized arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 20, 1960</u> , to <u>April 30, 1960</u> , that I last saw the deceased alive on <u>April 29, 1960</u> , and that death occurred at <u>6:15</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emily H. Wilson</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>4-30-60</u>			
PHYSICIAN'S NAME (Type) <u>Dr. L. L. Lottman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-3-60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Way of Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P.E. Sewell, Prince Frederick</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH COUNTY STATE		PLACE OF DEATH COUNTY STATE	
DATE OF BIRTH MONTH DAY YEAR		DATE OF DEATH MONTH DAY YEAR	
SEX MALE FEMALE		RACE WHITE COLORED OTHER	
OCCUPATION TRADE PROFESSION SERVICE		CAUSE OF DEATH (To be filled in by physician or coroner) 1. _____ 2. _____ 3. _____	
MANNER OF DEATH (To be filled in by physician or coroner) 1. _____ 2. _____ 3. _____		SIGNATURE OF PHYSICIAN OR CORONER _____ TITLE _____	
SIGNATURE OF REGISTRAR _____ TITLE _____		SIGNATURE OF WITNESS _____ TITLE _____	

This certificate is to be filled out by the physician or coroner who has examined the body and determined the cause and manner of death. It is to be filed with the local health officer, who will forward it to the State Department of Health. The State Department of Health will then forward it to the Federal Bureau of Investigation, which will use it for its own purposes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4184
64097
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. LENGTH OF STAY IN 1b 1 hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4016 Ritchie Hwy.				d. STREET ADDRESS 233 Meadow Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Kayle Middle Eckley Last 4. DATE OF DEATH Month April Day 18 Year 1960							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1911	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Finisher				10b. KIND OF BUSINESS OR INDUSTRY Flooring		11. BIRTHPLACE (State or foreign country) W. Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME John Eckley				14. MOTHER'S MAIDEN NAME Fannie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-12-7881		17. INFORMANT Mrs. Gladys Eckley Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 58 , 19 to Apr 60 , 19, that (I) (we) last saw the deceased alive on 18 Apr 60 , and that death occurred at 10 AM , from the causes and on the date stated above.							
22a. SIGNATURE Andrew R. Sosnowski				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE April 19, 1960 SIGNED	
22c. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski M.D.				22d. ADDRESS 4016 Ritchie Hwy. Balto. 25, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 21, 1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince George's Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Ronce				ADDRESS 4001 Ritchie Hwy. Balto		25a. REC'D BY REGISTRAR APR 20 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF TEST

1818

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4135 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 5 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			
				d. STREET ADDRESS Box 15 Waterbury			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Infant First Middle Last Edwards				4. DATE OF DEATH Month Day Year April 29 1960			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1960	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. yrs.		10. AGE (In years lost birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M. Edwards				14. MOTHER'S MAIDEN NAME Ila Mae Garnett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pressure due to 774X DUE TO Maternal cause (acute Pyelitis) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 29, 1960 to April 29, 1960 , that I last saw the deceased alive on April 29, 1960 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Rita Richardson				ADDRESS (Street, city or town, state) 110-CLAY STREET			
PHYSICIAN'S NAME (Type) Dr. Richardson				DATE SIGNED 4/30/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-60		22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Waterbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Hesse, Jr. - Annapolis, Md.				ADDRESS ANNE ARUNDEL CO., MD.		24a. REC'D BY REGISTRAR DATE MAY 3 1960	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4136 CERTIFICATE OF DEATH

64099

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle N. Last ELLZEY				4. DATE OF DEATH Month April Day 20 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 12, 1872	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88		11. IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min. 88		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JAMES Cheston				14. MOTHER'S MAIDEN NAME CHARLOTTE R STELLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) —			
17. INFORMANT Helen Cheston, West River Md.				Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Mar. 23, 1960 to April 19, 1960 , that (I) (we) last saw the deceased alive on Apr. 19, 1960 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Richard N. Peeler				22b. DATE SIGNED 4/20/60			
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/22/60			
23c. NAME OF CEMETERY OR CREMATORY Christ Church				23d. LOCATION (City, town, or county) (State) Owensville Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Bernard O. Hardisty, Salisbury, Md.				25a. REC'D BY REGISTRAR DATE APR 25 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas				25c. REGISTRAR'S NAME —			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4185

CERTIFICATE OF DEATH

04160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Log Inn</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Salghman</i> Last <i>Emory</i>		4. DATE OF DEATH Month <i>Apr</i> Day <i>1st</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 3 1871</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hotel Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel Owner</i>	
11. BIRTHPLACE (State or foreign country) <i>Queenstown Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Blanchard Emory</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bourke</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Hackett W. Emory</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vomiting, dehydration</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Prob. Carcinoma of the Stomach unknown</i> DUE TO (c) <i>-</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i>May</i> Day <i>5</i> Year <i>1959</i> Hour <i>11</i> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/5</i> 1959 to <i>3/19</i> 1960, that I last saw the deceased alive on <i>3/19</i> 1960, and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>98 Cathedral Street</i> DATE SIGNED <i>Edwin Davis, Jr.</i>			
ACTUAL SIGNATURE <i>Edwin Davis, Jr.</i>		M.D. <i>98 Cathedral Street</i>	
PHYSICIAN'S NAME (Type) <i>Edwin Davis, Jr., M. D.</i>		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Apr. 4-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St James Cent</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45		4. DATE OF DEATH 10/15/1918		5. PLACE OF DEATH Home	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Pneumonia		8. MANNER OF DEATH Natural		9. PLACE OF BURIAL St. Mary's Cemetery		10. NAME OF CLERGYMAN Rev. J. J. Smith	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		13. SIGNATURE OF PHYSICIAN J. J. Smith		14. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		15. SIGNATURE OF REGISTRAR J. J. Smith	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		18. SIGNATURE OF PHYSICIAN J. J. Smith		19. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		20. SIGNATURE OF REGISTRAR J. J. Smith	
21. SIGNATURE OF DECEASED (None)		22. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		23. SIGNATURE OF PHYSICIAN J. J. Smith		24. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		25. SIGNATURE OF REGISTRAR J. J. Smith	
26. SIGNATURE OF DECEASED (None)		27. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		28. SIGNATURE OF PHYSICIAN J. J. Smith		29. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		30. SIGNATURE OF REGISTRAR J. J. Smith	
31. SIGNATURE OF DECEASED (None)		32. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		33. SIGNATURE OF PHYSICIAN J. J. Smith		34. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		35. SIGNATURE OF REGISTRAR J. J. Smith	
36. SIGNATURE OF DECEASED (None)		37. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		38. SIGNATURE OF PHYSICIAN J. J. Smith		39. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		40. SIGNATURE OF REGISTRAR J. J. Smith	
41. SIGNATURE OF DECEASED (None)		42. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		43. SIGNATURE OF PHYSICIAN J. J. Smith		44. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		45. SIGNATURE OF REGISTRAR J. J. Smith	
46. SIGNATURE OF DECEASED (None)		47. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		48. SIGNATURE OF PHYSICIAN J. J. Smith		49. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		50. SIGNATURE OF REGISTRAR J. J. Smith	
51. SIGNATURE OF DECEASED (None)		52. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		53. SIGNATURE OF PHYSICIAN J. J. Smith		54. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		55. SIGNATURE OF REGISTRAR J. J. Smith	
56. SIGNATURE OF DECEASED (None)		57. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		58. SIGNATURE OF PHYSICIAN J. J. Smith		59. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		60. SIGNATURE OF REGISTRAR J. J. Smith	
61. SIGNATURE OF DECEASED (None)		62. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		63. SIGNATURE OF PHYSICIAN J. J. Smith		64. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		65. SIGNATURE OF REGISTRAR J. J. Smith	
66. SIGNATURE OF DECEASED (None)		67. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		68. SIGNATURE OF PHYSICIAN J. J. Smith		69. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		70. SIGNATURE OF REGISTRAR J. J. Smith	
71. SIGNATURE OF DECEASED (None)		72. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		73. SIGNATURE OF PHYSICIAN J. J. Smith		74. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		75. SIGNATURE OF REGISTRAR J. J. Smith	
76. SIGNATURE OF DECEASED (None)		77. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		78. SIGNATURE OF PHYSICIAN J. J. Smith		79. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		80. SIGNATURE OF REGISTRAR J. J. Smith	
81. SIGNATURE OF DECEASED (None)		82. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		83. SIGNATURE OF PHYSICIAN J. J. Smith		84. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		85. SIGNATURE OF REGISTRAR J. J. Smith	
86. SIGNATURE OF DECEASED (None)		87. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		88. SIGNATURE OF PHYSICIAN J. J. Smith		89. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		90. SIGNATURE OF REGISTRAR J. J. Smith	
91. SIGNATURE OF DECEASED (None)		92. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		93. SIGNATURE OF PHYSICIAN J. J. Smith		94. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		95. SIGNATURE OF REGISTRAR J. J. Smith	
96. SIGNATURE OF DECEASED (None)		97. SIGNATURE OF WITNESSES J. J. Smith, J. J. Smith		98. SIGNATURE OF PHYSICIAN J. J. Smith		99. SIGNATURE OF CLERGYMAN Rev. J. J. Smith		100. SIGNATURE OF REGISTRAR J. J. Smith	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND INDEXING.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4186 **CERTIFICATE OF DEATH**

64101

1. NAME OF DECEASED (Type or Print) Wilbur R. Erdman		2. DATE OF DEATH 4/29/60	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Kane Hospital</i> FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Brooklyn - 25 5210 Ballman Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md. b. COUNTY A.A. County c. CITY OR TOWN (If outside city limits, write RURAL and give township) 50 Brooklyn d. STREET ADDRESS (If rural, give location) 5210 Ballman Ave.	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10/11/86
9. AGE (In years last birthday) 73		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PO Carrier 10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Erdman		14. MOTHER'S MAIDEN NAME Jennie Reese	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Family
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 181.0 Carcinoma (Squamous cell) of Bladder with local metastases in the Pelvis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Heart Failure - Same		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years	
19a. DATE OF OPERATION Dec 1958		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex of Bladder	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from December 15th 1958 to April 29, 1960 that (I) (we) last saw the deceased alive on April 29, 1960 and that in (my) (our) opinion death occurred at 5A m., from the causes and on the date stated above.			
23a. SIGNATURE Four & Glass ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS 320 Patuxent Ave Box 25, Md	
23c. DATE SIGNED 4/30/60			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/2/60	24c. NAME OF CEMETERY OR CREMATORY Cedar Hill C-m.	24d. LOCATION (City, town, or county) (State) Brooklyn, Md.
25a. DATE RECEIVED BY HEALTH DEPT. MAY 2 1960		25b. NAME OF REGISTRAR William A. McCully	
25c. FUNERAL DIRECTOR McCully Funeral Homes		ADDRESS 130 E. Fort Ave.	

THIS IS A PERMANENT RECORD.
NO INFORMATION SHOULD BE CAREFULLY SUPPLIED.
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE OF CALIFORNIA
CERTIFICATE OF DEATH

1. Name of Deceased: _____
2. Sex: ☐ Male ☐ Female
3. Date of Birth: _____
4. Place of Birth: _____
5. Usual Residence: _____
6. Date of Death: _____
7. Time of Death: _____
8. Cause of Death: _____
9. Place of Death: _____
10. Signature of Physician: _____
11. Signature of Registrar: _____
12. Date of Registration: _____

13. Name of Informant: _____
14. Relationship to Deceased: _____
15. Signature of Informant: _____
16. Date of Information: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4137

CERTIFICATE OF DEATH

64102

Items 3, 13, 14 & 16 Film Q263 5/11/60 iwk

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Emergency Room) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) William First Middle Henry Last EVANS, Sr.		4. DATE OF DEATH April 14 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1880
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	

13. FATHER'S NAME CHARLES W. EVANS		14. MOTHER'S MAIDEN NAME Laura Virginia Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-34-9324	
17. INFORMANT WILLIAM H. EVANS JR.		Address #2	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331 X DUE TO Hypertension (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that (I) (this hospital) attended the deceased from April 1 1960 to April 14 1960, that (I) (we) last saw the deceased alive on April 14, 1960, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE A. L. ANDERSON		22b. DATE 4/15/60	
22c. PHYSICIAN'S NAME (Type) A. L. ANDERSON		22d. ADDRESS 44 Southgate Ave., Annapolis, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-16-60		23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City, town, or county) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Galt + Sons Annapolis, Md.				25a. REC'D BY REGISTRAR DATE APR 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1102

CERTIFICATE OF DEATH

1137



X

WILLIAM H. BROWN

CHURCHES - FARM



WILLIAM H. BROWN

WILLIAM H. BROWN
CHURCHES - FARM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
1
4187
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64103

1. PLACE OF DEATH o. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN lb 2mo. 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Mamie		First Fisher		Last Fisher		4. DATE OF DEATH Month 4 Day 22 Year 1960									
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1901-Sept. 16		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 7 Days 6 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) Unknown SHARPSBURG MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown CHARLES KEETS						14. MOTHER'S MAIDEN NAME Unknown ALICE									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypostatic Pneumonia DUE TO (c) Marked Emphysema												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----											
20c. TIME OF INJURY Month, Day, Year Hour 4:10 p. m. 19				20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) factory street office bldg. etc.		20f. (City or town) Keedysville		(County) Washington		(State) MD			
21. I certify that (I) (this hospital) attended the deceased from 2/19 19 60 to 4/22 19 60 , that (I) (we) last saw the deceased alive on 4/22 19 60 , and that death occurred at 4:10 M, from the causes and on the date stated above.															
22a. SIGNATURE Hildegard Heard Reissman M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 4/22/60							
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.				22d. ADDRESS Crownsville State Hospital, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF APR. 25, 1960		23c. NAME OF CEMETERY OR CREMATORY RED HILL CEMETERY				23d. LOCATION (City, town, or county) (State) KEEDYSVILLE WASH. CO. MD					
24. FUNERAL DIRECTOR'S SIGNATURE John E. West						ADDRESS BOONSBORO MD.		25a. REC'D BY REGISTRAR APR 28 '60		25b. REGISTRAR'S SIGNATURE Charles S. Hanna					

44103

CERTIFICATE OF DEATH

1812



THE STATE
OF MARYLAND
COUNTY OF BALTIMORE

1183

James H. Haver

James H. Haver

James H. Haver

James H. Haver

James H. Haver

James H. Haver

James H. Haver

1

James H. Haver

James H. Haver

James H. Haver

James H. Haver

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4189 CERTIFICATE OF DEATH

64105

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 3mo. 16 yrs. 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Eastport		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 314 Chester Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Gray Last Gray				4. DATE OF DEATH Month 4 Day 11 Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1897		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elias Booth				14. MOTHER'S MAIDEN NAME Julia Gamble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. } (b) Decubital Ulcers - Old Right Hemiparesis (c) Arteriosclerotic Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mendel-Bechterew, Bronchopneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. == p.m. == 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) =====		20f. (City or town) (County) (State) =====	
21. I certify that (I) (this hospital) attended the deceased from 1/4 19 44 to 4/11 1960 , that (I) (we) last saw the deceased alive on 4/11 19 60 , and that death occurred at 4:30 P. from the causes and on the date stated above.							
22a. SIGNATURE <i>Hildegard Heard Reissman</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/12/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-14-60		23c. NAME OF CEMETERY OR CREMATORY Arundel Neck		23d. LOCATION (City, town, or county) (State) Arundel Neck, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Anna [illegible]</i>				25a. REC'D BY REGISTRAR DATE APR 13 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

422.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4190 CERTIFICATE OF DEATH

64106
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena, RFD c. LENGTH OF STAY IN 1b 5 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena, RFD (Magothy Beach)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Magothy Beach		d. STREET ADDRESS Rt. 5 Box 191A, Riverside Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALLEN F. HAMPSHIRE		4. DATE OF DEATH Month 4 - Day 8 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2nd April 1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Armco Steel Co.	
11. BIRTHPLACE (State or foreign country) Hoffmansville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Hampshire		14. MOTHER'S MAIDEN NAME Clara Gibbons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Ethel P. Hampshire		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ATHEROSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 4-2, 1960 , to APRIL 10:45 PM, 1960 , that I last saw the deceased alive on 4-2, 1960 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-9-60			
ACTUAL SIGNATURE Leon C. Perry		M.D. Glen Burnie, Maryland	
PHYSICIAN'S NAME (Type) Leon C. Perry		M.D. Glen Burnie, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12th April 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn RFD, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraw		ADDRESS Glen Burnie, Maryland	
24a. REC'D BY REGISTRAR APR 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4201

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of witness		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of coroner		17. Signature of medical examiner		18. Signature of pathologist		19. Signature of toxicologist		20. Signature of other	
21. Signature of registrar		22. Signature of informant		23. Signature of witness		24. Signature of funeral director		25. Signature of undertaker	
26. Signature of coroner		27. Signature of medical examiner		28. Signature of pathologist		29. Signature of toxicologist		30. Signature of other	
31. Signature of registrar		32. Signature of informant		33. Signature of witness		34. Signature of funeral director		35. Signature of undertaker	
36. Signature of coroner		37. Signature of medical examiner		38. Signature of pathologist		39. Signature of toxicologist		40. Signature of other	
41. Signature of registrar		42. Signature of informant		43. Signature of witness		44. Signature of funeral director		45. Signature of undertaker	
46. Signature of coroner		47. Signature of medical examiner		48. Signature of pathologist		49. Signature of toxicologist		50. Signature of other	
51. Signature of registrar		52. Signature of informant		53. Signature of witness		54. Signature of funeral director		55. Signature of undertaker	
56. Signature of coroner		57. Signature of medical examiner		58. Signature of pathologist		59. Signature of toxicologist		60. Signature of other	
61. Signature of registrar		62. Signature of informant		63. Signature of witness		64. Signature of funeral director		65. Signature of undertaker	
66. Signature of coroner		67. Signature of medical examiner		68. Signature of pathologist		69. Signature of toxicologist		70. Signature of other	
71. Signature of registrar		72. Signature of informant		73. Signature of witness		74. Signature of funeral director		75. Signature of undertaker	
76. Signature of coroner		77. Signature of medical examiner		78. Signature of pathologist		79. Signature of toxicologist		80. Signature of other	
81. Signature of registrar		82. Signature of informant		83. Signature of witness		84. Signature of funeral director		85. Signature of undertaker	
86. Signature of coroner		87. Signature of medical examiner		88. Signature of pathologist		89. Signature of toxicologist		90. Signature of other	
91. Signature of registrar		92. Signature of informant		93. Signature of witness		94. Signature of funeral director		95. Signature of undertaker	
96. Signature of coroner		97. Signature of medical examiner		98. Signature of pathologist		99. Signature of toxicologist		100. Signature of other	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4138 **CERTIFICATE OF DEATH**

64107

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				/d. STREET ADDRESS 137 Archwood Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Forest Middle B. Last HARDER		4. DATE OF DEATH Month April Day 16 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1884		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY CITY FREMAN		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert L. Harder			14. MOTHER'S MAIDEN NAME Minnie McCabe				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Forest W. Harder		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/12/60 to 4/16/60 , that (I) (we) lost the deceased alive on 4/16/60 , and that death occurred at 1:15P M, from the causes and on the date stated above.							
22a. SIGNATURE Maurice Klawans				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/18/60	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans				22d. ADDRESS 31 Southgate Ave., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		Apr 19-1960		Cedar Bluff Cent		Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons Annapolis Md				25a. REC'D BY REGISTRAR DATE APR 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

AMERICAN UNIVERSITY OF HEALTH
OFFICE OF THE REGISTRAR
CERTIFICATE OF DEATH

4

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTY
SEX
AGE
RACE
RELIGION
MARRIAGE
EDUCATION
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
DATE

1

DECEASED
DATE
PLACE
CITY
STATE
COUNTY
SEX
AGE
RACE
RELIGION
MARRIAGE
EDUCATION
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4139

CERTIFICATE OF DEATH

Reg. Dist. No.

04108

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>aa.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis Md</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 Clifton Place</u>				d. STREET ADDRESS <u>18 Clifton Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CAROLYN Lee</u> Middle <u>Healy</u> Last				4. DATE OF DEATH Month <u>4</u> - Day <u>4</u> - Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3 1889</u> yrs.	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Davidsonville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard M. Waters</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Raymond J. Connell</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lungs</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of left Breast</u> (c) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several wks.</u> <u>Several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 - 26 1959</u> to <u>4 - 4 - 1960</u> , that I last saw the deceased alive on <u>4 - 3 - 1960</u> , and that death occurred at <u>5:25 A</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Oliver Purvis</u>				ADDRESS (Street, city or town, state) <u>40 Franklin St Annapolis Md</u>		DATE SIGNED <u>4/5/60</u>	
PHYSICIAN'S NAME (Type) <u>J. Oliver Purvis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sun</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4140

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>46 Lafayette Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Holt</u> Middle <u>Benjamin</u> Last <u>S.</u>				4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-74</u>		9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barber</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>Louis Wesley Holt</u>			14. MOTHER'S MARDEN NAME <u>Rebecca Holt</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edna Holt 46 Lafayette Ave Annapolis MD</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Internal due to hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension (Arterial disease)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>4/23</u> , 19 <u>60</u> , to <u>4/23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>60</u> , and that death occurred at <u>11:55</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>R. L. Richardson</u>				M.D. _____			
PHYSICIAN'S NAME (Type) <u>Dr. R. L. Richardson</u>				<u>110 Clay Street, Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-27-60</u>		<u>Brewer Hill</u>		<u>Annapolis MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash St Annapolis</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 3 60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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A15 (4)
A 9/59

64110

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3yrs. 7mos. 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lottie Jackson		4. DATE OF DEATH Month 4 Day 13 Year 19 60	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/15/1878	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 4 Days 13 Hours 19 Min. 60	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		12. KIND OF BUSINESS OR INDUSTRY unknown	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME John W. Matthews		16. MOTHER'S MAIDEN NAME Sarah	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		18. SOCIAL SECURITY NO. unknown	
19. INFORMANT Medical Records		Address	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Chronic Brain Syndrome Associated with Senile Arteriosclerosis			
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month 4 Day 13 Year 19 60 Home <input checked="" type="checkbox"/> p. m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (I) (this hospital) attended the deceased from 8/14 19 56 to 4/13 19 60 that (I) (we) last saw the deceased alive on 4/13 19 60 , and that death occurred at 10:45 P. M. from the causes and on the date stated above.			
28. SIGNATURE Hildegard Heard Reissmann		29. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4-14-60	
30. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D.		31. ADDRESS Crownsville State Hospital, Maryland	
32. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		33. DATE THEREOF 4-18-60	
34. NAME OF CEMETERY OR CREMATORY WESTERN STAR CEM		35. LOCATION (City, town, or county) (State) CATONSVILLE, Md.	
36. FUNERAL DIRECTOR'S SIGNATURE Donald R. Brown		37. ADDRESS 108 W. Montgomery St.	
38. REC'D BY REGISTRAR APR 18 1960		39. REGISTRAR'S SIGNATURE Hildegard Reissmann	

01110

1911 CERTIFICATE OF DEATH

443X

Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to fading and bleed-through.

NAME: _____

DATE: _____

PLACE: _____

CAUSE: _____

SIGNATURE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR (4)
156/9/59
Thurs

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4141
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4141
CERTIFICATE OF DEATH

04111

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH April 4 1960	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1960	
9. AGE (In years last birthday) 1		10. IF UNDER 1 YEAR 1 IF UNDER 24 HRS. 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Mack Kaham		14. MOTHER'S MAIDEN NAME Helen Marie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Sklektosis Pneumonia DUE TO (b) Pneumonia DUE TO (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH From Birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 2, 1960 to April 4, 1960 , that (I) (we) last saw the deceased alive on April 4, 1960 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Philip Briscoe		22b. DATE SIGNED 1:35P.	
22c. PHYSICIAN'S NAME (Type) Philip Briscoe		22d. ADDRESS 95 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-9-1960	
23c. NAME OF CEMETERY OR CREMATORY Broadneck		23d. LOCATION (City, town, or county) (State) St. Margaret Md	
24. FUNERAL DIRECTOR'S SIGNATURE William Kasey		25a. REC'D BY REGISTRAR Anna Md	
25b. REGISTRAR'S SIGNATURE Arthur S. Huns		DATE APR 13 '60	

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4142
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4142
CERTIFICATE OF DEATH

64112

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle JOHNSON Last JOHNSON				4. DATE OF DEATH Month April Day 7 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1896	
9. AGE (In years last birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Andrew Savoy		14. MOTHER'S MAIDEN NAME Sarah Catoll		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Chas Johnson		Address 1019 Smithville St. Anne		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, chronic Severe 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Carcinomatous DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis		(County) Anne Arundel		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1955 to Apr. 7, 1960 , that (I) (we) last saw the deceased alive on Apr. 7, 1960 , and that death occurred at 6:15P. M, from the causes and on the date stated above.							
22a. SIGNATURE A. T. Allen				22b. DATE 4/8/60		22c. PHYSICIAN'S NAME (Type) A. T. Allen	
22d. ADDRESS 62 Cathedral St., Annapolis, Md.				22e. REC'D BY REGISTRAR William Reese		22f. REGISTRAR'S SIGNATURE William Reese	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-1960		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town, or county) (State) Annapolis Md.	

199.2

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the name of the deceased, date of death, place of death, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4192

CERTIFICATE OF DEATH

Item 14 Film 8262 5/16/60 iwr

64113

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 24 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS unknown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE		First		Middle JOHNSON		Last		4. DATE OF DEATH Month 4 Day 8 Year 19 60	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1915		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A			
13. FATHER'S NAME Clarence Johnson				14. MOTHER'S MAIDEN NAME Mary unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT MEDICAL RECORDS					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 3/15/60 to 4/8/60 , that (I) (we) last saw the deceased alive on 4/8/60 , and that death occurred at 1:45M , from the causes and on the date stated above.									
22a. SIGNATURE Hildegard Heard Reissmann				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED A.M.			
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D.				22d. ADDRESS Crownsville State Hospital, 4/8/60					
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-12-60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Com		23d. LOCATION (City, town, or county) _____ (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE Frances A. Hemmly				ADDRESS 576 W. 8th St. Baltimore		25a. REG'D BY REGISTRAR APR 12 60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MEDICAL CERTIFICATION

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4193 CERTIFICATE OF DEATH

64114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>P. O. Box 272</u>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>August</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1907</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Burner Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles A. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Niemann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-12-4248</u>	
17. INFORMANT <u>L. Thelma Johnson (Wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) <u>4 years</u> INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>60</u> , and that death occurred at <u>11:50</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles B. MacDonnell</u> M.D.		ADDRESS (Street, city or town, state) <u>204 Crown Hwy. Gb</u> DATE SIGNED <u>4-9-60</u>	
PHYSICIAN'S NAME (Type) <u>John Burnie Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. Funt</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

181.0

4143

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>30 N. Glen Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY E JONES</u>				4. DATE OF DEATH Month Day Year <u>APRIL 5 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3, 1874</u>	9. AGE (In years lost birthday) yrs. <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
13. FATHER'S NAME <u>GEORGE WILL</u>				14. MOTHER'S MAIDEN NAME <u>Mary Earheart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Sewell Sweeney- Daughter- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic atherosclerotic cardiovascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>5 pm.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Remington, Virginia</u>		(County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/7/60</u> , 19 <u>60</u> , and that death occurred at <u>6:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral Street, Annapolis, Maryland</u> DATE SIGNED <u>4/7/60</u>							
ACTUAL SIGNATURE <u>John H. Hedeman</u>		M.D. _____					
PHYSICIAN'S NAME (Type) <u>Frank Shipley - MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Remington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Remington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>APR 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4144

CERTIFICATE OF DEATH

04116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HUNNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>GAMBRILLS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H.A. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OLGA</u> Middle <u>KISSER</u> Last <u>KISSER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>N. DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GUSTAVE HARMEL</u>		14. MOTHER'S MAIDEN NAME <u>JULIA LENZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>RICHARD KISSER</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO <u>Coronary Arteriosclerosis</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/11/60</u> , 19 <u>60</u> , to <u>4/11/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>60</u> , and that death occurred at <u>8:40 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		DATE SIGNED <u>4/11/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-14-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OAK</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1116

CERTIFICATE OF DEATH

4 20.0

NAME OF DECEASED JAMES H. HARRIS		AGE 42		SEX Male		RACE White		DATE OF DEATH 11-15-1916		PLACE OF DEATH Home	
FATHER'S NAME JAMES H. HARRIS		MOTHER'S NAME MARY E. HARRIS		BIRTH DATE 11-15-1874		BIRTH PLACE Baltimore, Md.		EDUCATION High School		OCCUPATION Clerk	
PREVAILING DISEASE Tuberculosis		CAUSE OF DEATH Tuberculosis		PERIOD OF ILLNESS 6 months		PLACE OF ILLNESS Home		DATE OF BURIAL 11-18-1916		PLACE OF BURIAL St. Mary's Cemetery	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF FUNERAL DIRECTOR J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS	

4194

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>60 Glen Burnie</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4 Ferndale Ave., Ferndale</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HATTIE</i>		First <i>KLEIN</i> Middle Last		4. DATE OF DEATH Month <i>4</i> Day <i>13</i> Year <i>1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-22-1897</i>	9. AGE (In years last birthday) <i>62</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assembly Work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Calvert Distillery</i>		11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. FATHER'S NAME <i>John Leineweber</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Butger</i>			
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-01-6135</i>		17. INFORMANT Address <i>Mr. Elmer L. Klein Same As #2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> (c) <i>Arteriosclerosis general</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>diabetes mellitus</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Mar</i> , 1960, to <i>April 13</i> , 1960, that I last saw the deceased alive on <i>April 11</i> , 1960, and that death occurred at <i>_____</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph Taler</i> , M.D.				ADDRESS (Street, city or town, state) <i>102 Bx A Blvd. N.E.</i>			
PHYSICIAN'S NAME (Type) <i>JOSEPH TALER, M.D.</i>				DATE SIGNED <i>Glen Burnie, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>16 Apr - 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. S. Singleton</i>				ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 18 '60</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

428.0

4195 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co MD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CHELSEA BEACH</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>KORDECKI</u> Last <u>KORDECKI</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 19-1891</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ships</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Kordecki</u>		14. MOTHER'S MAIDEN NAME <u>Zysk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>215-05-3283</u>	
17. INFORMANT <u>HELEN-TURC</u> Address <u>Chelsea Beach A.A. Co</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 31, 1960</u> , to <u>April 9, 1960</u> , that I last saw the deceased alive on <u>April 7, 1960</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.M. McLaughlin</u> M.D.		ADDRESS (Street, city or town, state) <u>308 Mountain Road Pasadena Md</u> DATE SIGNED <u>April 9, 1960</u>	
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/12/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>	22d. LOCATION (City, town, or county) (State) <u>Balto, Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u> ADDRESS <u>2007 Eastern ave</u>		24a. REC'D BY REGISTRAR <u>APR 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Cuthbert L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. RACE <i>White</i>		4. DATE OF BIRTH <i>1910-01-01</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>	
6. DATE OF DEATH <i>1960-01-01</i>		7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>		10. SIGNATURE OF DECEASED <i>John Doe</i>	
11. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		12. SIGNATURE OF PHYSICIAN <i>John Doe</i>		13. SIGNATURE OF CLERK <i>John Doe</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF JUDGE <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>		19. SIGNATURE OF CLERK <i>John Doe</i>		20. SIGNATURE OF REGISTRAR <i>John Doe</i>	
21. SIGNATURE OF JUDGE <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		24. SIGNATURE OF PHYSICIAN <i>John Doe</i>		25. SIGNATURE OF CLERK <i>John Doe</i>	
26. SIGNATURE OF REGISTRAR <i>John Doe</i>		27. SIGNATURE OF JUDGE <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		30. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
31. SIGNATURE OF CLERK <i>John Doe</i>		32. SIGNATURE OF REGISTRAR <i>John Doe</i>		33. SIGNATURE OF JUDGE <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF NEXT OF KIN <i>John Doe</i>	
36. SIGNATURE OF PHYSICIAN <i>John Doe</i>		37. SIGNATURE OF CLERK <i>John Doe</i>		38. SIGNATURE OF REGISTRAR <i>John Doe</i>		39. SIGNATURE OF JUDGE <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		42. SIGNATURE OF PHYSICIAN <i>John Doe</i>		43. SIGNATURE OF CLERK <i>John Doe</i>		44. SIGNATURE OF REGISTRAR <i>John Doe</i>		45. SIGNATURE OF JUDGE <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		48. SIGNATURE OF PHYSICIAN <i>John Doe</i>		49. SIGNATURE OF CLERK <i>John Doe</i>		50. SIGNATURE OF REGISTRAR <i>John Doe</i>	
51. SIGNATURE OF JUDGE <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		54. SIGNATURE OF PHYSICIAN <i>John Doe</i>		55. SIGNATURE OF CLERK <i>John Doe</i>	
56. SIGNATURE OF REGISTRAR <i>John Doe</i>		57. SIGNATURE OF JUDGE <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		60. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
61. SIGNATURE OF CLERK <i>John Doe</i>		62. SIGNATURE OF REGISTRAR <i>John Doe</i>		63. SIGNATURE OF JUDGE <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF NEXT OF KIN <i>John Doe</i>	
66. SIGNATURE OF PHYSICIAN <i>John Doe</i>		67. SIGNATURE OF CLERK <i>John Doe</i>		68. SIGNATURE OF REGISTRAR <i>John Doe</i>		69. SIGNATURE OF JUDGE <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		72. SIGNATURE OF PHYSICIAN <i>John Doe</i>		73. SIGNATURE OF CLERK <i>John Doe</i>		74. SIGNATURE OF REGISTRAR <i>John Doe</i>		75. SIGNATURE OF JUDGE <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		78. SIGNATURE OF PHYSICIAN <i>John Doe</i>		79. SIGNATURE OF CLERK <i>John Doe</i>		80. SIGNATURE OF REGISTRAR <i>John Doe</i>	
81. SIGNATURE OF JUDGE <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		84. SIGNATURE OF PHYSICIAN <i>John Doe</i>		85. SIGNATURE OF CLERK <i>John Doe</i>	
86. SIGNATURE OF REGISTRAR <i>John Doe</i>		87. SIGNATURE OF JUDGE <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		90. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
91. SIGNATURE OF CLERK <i>John Doe</i>		92. SIGNATURE OF REGISTRAR <i>John Doe</i>		93. SIGNATURE OF JUDGE <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF NEXT OF KIN <i>John Doe</i>	
96. SIGNATURE OF PHYSICIAN <i>John Doe</i>		97. SIGNATURE OF CLERK <i>John Doe</i>		98. SIGNATURE OF REGISTRAR <i>John Doe</i>		99. SIGNATURE OF JUDGE <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

4196 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md</u>				c. LENGTH OF STAY IN 1b <u>5 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 Martin Rd.</u>				e. STREET ADDRESS <u>2705 Cleveland St</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Paceli</u> Last <u>Krauser</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 2, 1894</u>	
9. AGE (In years last birthday) <u>65</u>		10. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		11. IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>174-16-0965</u>			
11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Paceli</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Same</u>			
17. INFORMANT <u>Mary Ann Brown</u>				Address <u>101 Martin Rd. Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>							
DUE TO <u>Pulmonary Edema</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma</u>							
DUE TO <u>Bronchogenic Carcinoma</u>							
DUE TO <u>Emphysema</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat. white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 5, 1960</u> , to <u>April 27, 1960</u> , that I last saw the deceased alive on <u>April 26, 1960</u> , and that death occurred at <u>12:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.W. Prichard</u>				DATE SIGNED <u>4/27/60</u>			
PHYSICIAN'S NAME (Type) <u>R.W. PRICHARD</u>				ADDRESS <u>715 Cottage Rd. Glen Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lafferty, Kirkley & Son, Inc.</u>				ADDRESS <u>Glen Burnie, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>APR 29 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64120

4145

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital (DOA)				d. STREET ADDRESS 30 Murray Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Morris		First Middle Last LEGUM		4. DATE OF DEATH Month Day Year April 18 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1876		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Investor				10b. KIND OF BUSINESS OR INDUSTRY Rental of Own Properties		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Julius Legum				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				(County) Maryland			
21. I certify that (I) (this hospital) attended the deceased from 6/20 1959 to 4/18 1960, that (I) (we) lost the deceased on 2/2 1960, and that death occurred at 7:55A. M, from the causes and on the date stated above.							
22a. SIGNATURE Richard N. Peeler				22b. DATE SIGNED 4/18/60			
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr, 20, 1960		23c. NAME OF CEMETERY OR CREMATORY Mikro Kodesh Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				25a. REC'D BY REGISTRAR DATE APR 22 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

CERTIFICATE OF DEATH

1156

1156

Name of Deceased

Married

Age of Deceased

Residence

Occupation

Place of Death (Full Name of Hospital)

Date of Death

Time of Death

Place of Death

Signature of Medical Officer

Signature of Registrar

Signature of Coroner

Signature of Deceased

Signature of Medical Officer

Signature of Registrar

Signature of Coroner

1156

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1864121										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>47X-3</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b <u>1 day</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. STREET ADDRESS <u>Mash. DC</u>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Everett</u> Last <u>Mason</u>					4. DATE OF DEATH Month <u>Apr</u> - Day <u>17</u> Year <u>1960</u>					
5. SEX <u>m</u>	6. COLOR OR RACE <u>BL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26, 1923</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baggage Porter</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Mash. Terminal</u>		11. BIRTHPLACE (State or foreign country) <u>St Marys Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James C. Mason</u>					14. MOTHER'S MAIDEN NAME <u>Beatrice R. Jones</u> <u>1411 Y St SE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 11</u>		17. INFORMANT <u>Mrs. Mary Mason</u>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell overboard from boat while boating</u>							
20c. TIME OF INJURY Month, Day, Year <u>2:30</u> Hour <u> </u> p. m. <u>4/17/</u> 19 <u>60</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back Creek</u>		20f. (City or town) <u>Annapolis</u> (County) <u>AA</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>S. Boersuck</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>4/17/60</u>				
EXAMINER'S NAME (Type) <u>S. Boersuck</u>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>acting</u>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>April 22-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Urbington National</u>		22d. LOCATION (City, town, or county) <u>Fort Meyer</u> (State) <u>VA</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Hazen Funeral Home</u> ADDRESS <u>389-R.D. Avenue DE</u>		
24a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>								

10. *Chlorophyll a* and *Chlorophyll b* were determined using a spectrophotometer (Shimadzu UV-1601) at 663 nm and 646 nm, respectively. The concentration of chlorophyll was calculated using the following formula:

4197

CERTIFICATE OF DEATH

64123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mountain Road</u>		d. STREET ADDRESS <u>Rt. 7 Box 327 Mountain Road</u>	
3. NAME OF DECEASED (Type or print) First <u>PIERCE T.</u> Middle <u>MEAGHER</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1874</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Philip T. Meagher</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Potter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-0791</u>	
17. INFORMANT <u>Mrs. Jane C. Meagher</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>2 months</u> <u>2 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 15, 1959</u> to <u>April 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>60</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3708 Mountain Rd Pasadena, Md April 30, 1960</u>	
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>May 3, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Taylor Ave. Balto. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>		ADDRESS <u>4001 Ritchie Hwy. (25)</u>	
24a. REC'D BY REGISTRAR <u>MAY 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		HOSPITAL	
1. NAME OF DECEASED		2. DATE OF DEATH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. PLACE OF BIRTH		8. DATE OF BIRTH	
9. MARITAL STATUS		10. EDUCATION	
11. RELIGION		12. RACE	
13. PREVIOUS ILLNESS		14. MEDICAL HISTORY	
15. SURVIVAL OF DEATH		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF CLERK		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF SHERIFF		22. SIGNATURE OF CORONER	
23. SIGNATURE OF JURY		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF SHERIFF		26. SIGNATURE OF CORONER	
27. SIGNATURE OF JURY		28. SIGNATURE OF JUDGE	
29. SIGNATURE OF SHERIFF		30. SIGNATURE OF CORONER	
31. SIGNATURE OF JURY		32. SIGNATURE OF JUDGE	
33. SIGNATURE OF SHERIFF		34. SIGNATURE OF CORONER	
35. SIGNATURE OF JURY		36. SIGNATURE OF JUDGE	
37. SIGNATURE OF SHERIFF		38. SIGNATURE OF CORONER	
39. SIGNATURE OF JURY		40. SIGNATURE OF JUDGE	
41. SIGNATURE OF SHERIFF		42. SIGNATURE OF CORONER	
43. SIGNATURE OF JURY		44. SIGNATURE OF JUDGE	
45. SIGNATURE OF SHERIFF		46. SIGNATURE OF CORONER	
47. SIGNATURE OF JURY		48. SIGNATURE OF JUDGE	
49. SIGNATURE OF SHERIFF		50. SIGNATURE OF CORONER	
51. SIGNATURE OF JURY		52. SIGNATURE OF JUDGE	
53. SIGNATURE OF SHERIFF		54. SIGNATURE OF CORONER	
55. SIGNATURE OF JURY		56. SIGNATURE OF JUDGE	
57. SIGNATURE OF SHERIFF		58. SIGNATURE OF CORONER	
59. SIGNATURE OF JURY		60. SIGNATURE OF JUDGE	
61. SIGNATURE OF SHERIFF		62. SIGNATURE OF CORONER	
63. SIGNATURE OF JURY		64. SIGNATURE OF JUDGE	
65. SIGNATURE OF SHERIFF		66. SIGNATURE OF CORONER	
67. SIGNATURE OF JURY		68. SIGNATURE OF JUDGE	
69. SIGNATURE OF SHERIFF		70. SIGNATURE OF CORONER	
71. SIGNATURE OF JURY		72. SIGNATURE OF JUDGE	
73. SIGNATURE OF SHERIFF		74. SIGNATURE OF CORONER	
75. SIGNATURE OF JURY		76. SIGNATURE OF JUDGE	
77. SIGNATURE OF SHERIFF		78. SIGNATURE OF CORONER	
79. SIGNATURE OF JURY		80. SIGNATURE OF JUDGE	
81. SIGNATURE OF SHERIFF		82. SIGNATURE OF CORONER	
83. SIGNATURE OF JURY		84. SIGNATURE OF JUDGE	
85. SIGNATURE OF SHERIFF		86. SIGNATURE OF CORONER	
87. SIGNATURE OF JURY		88. SIGNATURE OF JUDGE	
89. SIGNATURE OF SHERIFF		90. SIGNATURE OF CORONER	
91. SIGNATURE OF JURY		92. SIGNATURE OF JUDGE	
93. SIGNATURE OF SHERIFF		94. SIGNATURE OF CORONER	
95. SIGNATURE OF JURY		96. SIGNATURE OF JUDGE	
97. SIGNATURE OF SHERIFF		98. SIGNATURE OF CORONER	
99. SIGNATURE OF JURY		100. SIGNATURE OF JUDGE	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4147 CERTIFICATE OF DEATH

64124

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS 328 First St.			
3. NAME OF DECEASED (Type or print) First Robert Middle G Last MIDDLETON				4. DATE OF DEATH Month April Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Watchman				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Ralph Middleton				14. MOTHER'S MAIDEN NAME Katherine Burns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. none			
17. INFORMANT Hospital Records,				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 HOURS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE MONOBLASTIC LEUKEMIA							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 4, 1960 to April 18, 1960 , that (I) (we) last saw the deceased alive on April 18, 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Edward S. Beck				22b. DATE SIGNED 4/19/60			
22c. PHYSICIAN'S NAME (Type) Edward S. Beck				22d. ADDRESS 21 FRANKLIN ST. 41 Southgate Ave., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 22, 1960		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				25a. REC'D BY REGISTRAR DATE APR 22 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

01181

CERTIFICATE OF DEATH

1817

THIS CERTIFICATE

WAS ISSUED

ON THE

ANNUAL

REPORT

SEE PAGE 10

THE DEATH OF

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4148

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>C.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>117 Smith Ave.</u>		d. STREET ADDRESS <u>117 Smith Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FLORENCE FISHER MORGAN</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS A. FISHER</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. PARKINSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>RAYMOND C. MORGAN</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>10</u> p. m. <u>15</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>APR 7/60</u>	
EXAMINER'S NAME (Type) <u>E. L. WALKER</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-11-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR</u>		ADDRESS <u>SOVS ANNAPOLIS MD</u>	
24a. REC'D BY REGISTRAR <u>APR 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

4344

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>JOHN J. BROWN</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>10-15-1918</i>		PLACE OF DEATH <i>Home</i>	
CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	
OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>	
MARRIED <i>Yes</i>		SINGLE <i>No</i>	
WIDOWED <i>No</i>		DIVORCED <i>No</i>	
SEPARATED <i>No</i>		OTHER <i>No</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DISEASE OR INJURY <i>Myocardial Infarction</i>		TOXIC <i>No</i>	
TRAUMA <i>No</i>		SUICIDE <i>No</i>	
HOMICIDE <i>No</i>		OTHER <i>No</i>	
SIGNATURE OF EXAMINER <i>John J. Brown</i>		DATE <i>10-15-1918</i>	
OFFICE <i>Baltimore</i>		COUNTY <i>Harford</i>	
STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4198 CERTIFICATE OF DEATH

64126

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Arnoel md</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter Chase Munroe</u> First Middle Last				4. DATE OF DEATH <u>4-5-60</u> Month Day Year			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 Aug. 1889</u> yrs. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James M. Munroe</u>				14. MOTHER'S MAIDEN NAME <u>Mary Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>yes Navy W.W.I.</u>				16. SOCIAL SECURITY NO. <u>Wife Lydia Joyce Munroe (2)</u>			
17. INFORMANT <u>Wife Lydia Joyce Munroe (2)</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Emphysema (marked)</u> DUE TO <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>1960</u> , that (I) (we) last saw the deceased alive on <u>4-4-60</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. Hahn</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>				22d. ADDRESS <u>Severna Park md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Apr. 8th 1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>				23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				25a. REC'D BY REGISTRAR <u>APR 8 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>				25c. REGISTRAR'S SIGNATURE			

04127

4149 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 HOUSLEY ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>MOSLEY</u> Last <u>MUNTZ</u>		DATE OF DEATH Month <u>APRIL</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 6, 1878</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JAMES CARNEY</u>	
14. MOTHER'S MAIDEN NAME <u>HARRIETT DURHAM</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>Miss Icky Mosley #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952</u> to <u>April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>60</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis J. Codd</u>		ADDRESS (Street, city or town, state) <u>P.O. Box 289</u>	
PHYSICIAN'S NAME (Type) <u>1</u>		DATE SIGNED <u>4-24-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr-28-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hellcrest Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-15-20
Name of Deceased
Age
Sex
Date of Birth
Place of Birth
Date of Death
Place of Death
Cause of Death
Disease or Injury
Occupation
Signature of Physician
Signature of Registrar
Date of Registration

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4199 CERTIFICATE OF DEATH

04128

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>BALTIMORE</u> b. COUNTY <u>ANN A. A. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middlebrook</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BORD STONE RD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sands Nursing Home</u>				d. STREET ADDRESS <u>1 ASHDALE</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles S. Nicholson</u> First Middle Last				4. DATE OF DEATH <u>4/27</u> Month Day Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-22-85</u> 9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1510</u>		11. BIRTHPLACE (State or foreign country) <u>IND.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James S. Nicholson</u>				14. MOTHER'S MAIDEN NAME <u>Christina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FAMILY</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>334</u> IMMEDIATE CAUSE (a) <u>Grave Lobar Pneumonia</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Infarct + Hemiplegia</u> (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> <u>1960</u> to <u>4/24</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> <u>1960</u> , and that death occurred at <u>2:40</u> <u>PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. J. Lipskey</u>				22b. DATE SIGNED <u>4/27/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKEY</u>				22d. ADDRESS <u>Odenton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>4-30-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London RE</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nichols - 130 E Towler</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

ON JOSEPH LIPSKY
CHARTER MAY 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64129

4150 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND				c. LENGTH OF STAY IN 1b 3hrs 52minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALLEN WAYNE Middle PARKS Last				4. DATE OF DEATH Month April Day 17 Year 1960			
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 APRIL 1960	9. AGE (In years last birthday) yrs. 3 Months 5 Days 17 Hours 52 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND		
13. FATHER'S NAME Walter W. PARKS			14. MOTHER'S MAIDEN NAME Attie Rena PELOQUIN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. ---		17. INFORMANT FATHER Walter W. PARKS Address 230 Sycomore Court Annapolis, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROPS FETALIS 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3hrs 52 min.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 01474 5/17 , 19 60 , to 0440 5/17 , 19 60 , that I last saw the deceased alive on 0440 5-17 , 19 60 , and that death occurred at 0440 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Frederic M. Kenny M.D. U.S. NAVAL HOSPITAL ANNAPOLIS, MARYLAND							
PHYSICIAN'S NAME (Type) Frederic M. KENNY LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Apr. 19-1960		Naval Academy		Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Sons				24a. REC'D BY REGISTRAR DATE APR 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

2051353XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G261 4/29/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

04130

4200

1. PLACE OF DEATH a. COUNTY <u>Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Marley Neck Road, Glen Burnie Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at her home-18 Marley Neck Rd.</u>		d. STREET ADDRESS <u>18 Marley Neck Rd, Glen Burnie</u>	
3. NAME OF DECEASED (Type or print) <u>LILLIAN</u> First <u>BELL</u> Middle <u>PFEIFER</u> Last		4. DATE OF DEATH <u>April</u> Month <u>23</u> Day <u>1960</u> Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lynchburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mathew Floyd</u>		14. MOTHER'S MAIDEN NAME <u>ELLA MAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. Vola McLaughlin</u> Address <u>Shore Acres Arundel County</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic heart disease.</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of left breast</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 4, 1960</u> , to <u>April 23, 1960</u> , that I last saw the deceased alive on <u>April 23, 1960</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmond I. Moushalek</u> M.D.		ADDRESS (Street, city or town, state) <u>2101 S. Ritchie Highway</u> DATE SIGNED <u>4/23/60</u>	
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>		<u>Glen Burnie, Maryland</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 25-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Rd Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barbara G. Fink</u> ADDRESS <u>Glen Burnie Md</u>		24a. REC'D BY REGISTRAR <u>APR 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64131											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 1, Box 179						d. STREET ADDRESS Rt. 1, Box 179					
3. NAME OF DECEASED (Type or print) First MARY Middle ESTHER Last PHILIPS						4. DATE OF DEATH Month April Day 25 Year 19 60					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1928		9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) ANNE ARUNDEL CO. MD.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME SAMUEL WILLIAMS				14. MOTHER'S MAIDEN NAME SADIE SHORTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.				17. INFORMANT SADIE WILLIAMS RT 1, Box 179 Laurel			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pneumonitis. DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Charles S. Petty, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4/25/60		22c. NAME OF CEMETERY OR CREMATORY BACONS		22d. LOCATION (City, town, or country) (State) Anne Arundel Co. Md.			
23. FUNERAL DIRECTOR Ridgely Selby 1200 Sparrow Place Laurel Md.						24a. REC'D BY REGISTRAR MAY 2 '60		24b. REGISTRAR'S SIGNATURE Charles S. Petty			

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4151

CERTIFICATE OF DEATH

64132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>PERRY</u> Last <u>POOLE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1881</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William E. Perry</u>				14. MOTHER'S MAIDEN NAME <u>Sally Crandall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Nelen S. Stallings 1871 Cherry Grove Ave Annapolis Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>Apr. 13,</u> 19 <u>60</u> , to <u>Apr. 26,</u> 19 <u>60</u> , that I last saw the deceased alive on <u>April 26,</u> 19 <u>60</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u>				ADDRESS (Street, city or town, state) <u>71 Franklin St., Annapolis, Md.</u>		DATE SIGNED <u>4/27/60</u>	
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>				PHYSICIAN'S ADDRESS <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 29-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		22d. LOCATION (City, town, county) (State) <u>Tracey Landing Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>APR 29 '60</u>				DATE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4202

CERTIFICATE OF DEATH

64133

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SOPHIE</u> Middle <u>PRICE</u> Last <u>PRICE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 December 1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas Lerch</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		INFORMANT <u>John Price (Husband)</u>		Address <u>Rt. 2 Box 84, Severn, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction, Right Long</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease with Atrial Fibrillation</u> DUE TO (c) <u>Multiple Pulmonary Emboli</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Hypertensive Cardiovascular Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>18 November, 1958</u> to <u>20 April, 1960</u> , that I last saw the deceased alive on <u>20 April, 1960</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>20 Apr 60</u>							
ACTUAL SIGNATURE <u>Stanley Siegelman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>STANLEY SIEGELMAN, CAPT., MC</u>				US Army Hospital, Ft George G. Meade, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware</u> <u>Singleton Funeral Home</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

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CERTIFICATE OF DEATH

4202



4152

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				/d. STREET ADDRESS 106 Clay St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle QUEEN Last QUEEN				4. DATE OF DEATH Month April Day 27 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1890		9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Queen				14. MOTHER'S MAIDEN NAME Louise Queen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-16-0546		17. INFORMANT Nancy Queen		Address Annapolis Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Is congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vascular Disease DUE TO (c) 4 yrs						INTERVAL BETWEEN ONSET AND DEATH 3/15 E 4/20/60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 14, 19 60 , to Apr. 26, 19 60 , that I last saw the deceased alive on April 26, 19 60 , and that death occurred at 7:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE T. H. Johnson				ADDRESS (Street, city or town, state) 37 Calvert St.,		DATE SIGNED 4/27/60	
PHYSICIAN'S NAME (Type) T. H. Johnson				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-1960		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Beckett				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE MAY 3 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 261 4-22-60 ams										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 64136	
4203										CERTIFICATE OF DEATH	
Reg. Dist. No.										27	
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade c. LENGTH OF STAY IN 1b 3 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY San Diego c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) San Diego d. STREET ADDRESS 4275 Swift St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First GLADYS Middle - Last RECORD					4. DATE OF DEATH Month April Day 4 Year 1960						
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Sept 60		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Nebraska			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -					16. SOCIAL SECURITY NO. -		INFORMANT (Son) Bille Record Address US Naval Security Gp Activity Ft Geo G Meade, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 904.0 DUE TO Trauma to skull and bleeding diathesis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 14 hrs. (c) 14 hrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Polycythemia, vera with bleeding diathesis											
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell and struck left temple						
20c. TIME OF INJURY Month, Day, Year 8:00 AM Apr. 4 1960					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Son's home		20f. (City or town) Ft. Geo. Meade A.A. (County) Md. (State)		
21. I certify that I attended the deceased from 4 April , 1960, to 4 April , 1960, that I last saw the deceased alive on 4 April , 1960, and that death occurred at 9:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) San Diego California DATE SIGNED 4 April 1960											
ACTUAL SIGNATURE Nathaniel S Beard, M.D.					NATHANIEL S BEARD, Capt., M.C.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4/11/60		22c. NAME OF CEMETERY OR CREMATORY De Witt Donaldson Laurel Md			22d. LOCATION (City, town, or county) San Diego California (State)	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson Laurel Md					ADDRESS		24a. REC'D BY REGISTRAR APR 8 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Travis		

4203

California

San Diego

4275 Gulf St

April

1900

17th St

11A

11A

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US Army, 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ANNAPOLIS
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64137

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 5 S. Cherry Grove Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mabel SCHOTT		4. DATE OF DEATH Month Day Year April 16 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1889
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Nlman		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Charles H. Schott		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of cervix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 171X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 55 to April 16 19 60 , that (I) (we) last saw the deceased alive on April 16 19 60 , and that death occurred at 11:40A. M, from the causes and on the date stated above.			
22a. SIGNATURE John L. Hedeman		22b. DATE SIGNED 4/18/60	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 20-1960	
23c. NAME OF CEMETERY OR CREMATORY National Cent		23d. LOCATION (City, town, or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		25a. REC'D BY REGISTRAR APR 20 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Hume			

CERTIFICATE OF DEATH

4193

NAME OF DECEASED

LAST NAME

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

DATE OF BIRTH

SEX

DATE OF DEATH

DATE OF BIRTH

U.S.

STATE

TO THE WIFE

CLAUDE H. HARRIS

CLAUDE H. HARRIS

CLAUDE H. HARRIS

4193

CLAUDE H. HARRIS

CLAUDE H. HARRIS

CLAUDE H. HARRIS

CLAUDE H. HARRIS

CLAUDE H. HARRIS

4165

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Annapolis Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Melling</u> Last <u>SHARKEY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1882</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min.		11. BIRTHPLACE (State or foreign country) <u>NYC</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Office</u>		11. BIRTHPLACE (State or foreign country) <u>NYC</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>064 09 7045</u>			
17. INFORMANT <u>Mrs. Elizabeth M. Sharkey- Wife- same as # 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular hemorrhage</u> 33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1. Generalized arteriosclerosis.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>19 56</u> to <u>April</u> , <u>1960</u> , that I last saw the deceased alive on <u>April 1</u> , <u>19 60</u> and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park, Maryland</u> DATE SIGNED <u>4-4-60</u> ACTUAL SIGNATURE <u>Francis I. Codd</u> M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>April 6, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Maryland</u> 24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1963

John A. Smith

November 1963

November 1963

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

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4154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G260 4/11/601b

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Virginia Last Shelton		4. DATE OF DEATH Month April Day 2 Year 1960	
5. SEX Female	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/07
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) DEALE MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES FORD		14. MOTHER'S MAIDEN NAME MARY L. LOYD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT R. VERNON SHELTON		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Maddive Internal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stab wound of abdomen, with transection of right common iliac artery DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed self in abdomen with kitchen knife	
20c. TIME OF INJURY Month, Day, Year Hour 4/2 19 60 a. m. 0 p. m. 0		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Annapolis, Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE W. Bradley King, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. Bradley King, Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 3, 1960	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 5 1960	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sr.		ADDRESS Annapolis Md	
24a. REC'D BY REGISTRAR APR 6 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 10-1-19 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
RACE [Illegible]		OCCUPATION [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		SIGNATURE OF EXAMINER [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]	

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4155

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
		d. STREET ADDRESS St. Margarets	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle A. Last SIMMONS		4. DATE OF DEATH Month April Day 26 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 6, 1870
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Robert Simmons		14. MOTHER'S MAIDEN NAME Ellen ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Ella Simmons		Address Wife same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Atrophy & psychosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Similarity			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fall down steps 6 wks. ago -			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 3, 1960 to April 25, 1960 , that I last saw the deceased alive on April 25, 1960 , and that death occurred at 3:15 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Maurice Klawans		ADDRESS (Street, city or town, state) DATE SIGNED 31 Southgate Ave., Annapolis, Md. 4/26/60	
PHYSICIAN'S NAME (Type) Maurice Klawans		Annapolis, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 28, 1960	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	24a. REC'D BY REGISTRAR DATE APR 29 '60
		24b. REGISTRAR'S SIGNATURE <i>Anthony L. Krawiec</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH (State, County, and Township)		DATE OF BIRTH (Month, Day, and Year)	
SEX (Male or Female)		RACE (White, Black, or Other)	
OCCUPATION (If any)		CAUSE OF DEATH (If known)	
PLACE OF DEATH (State, County, and Township)		DATE OF DEATH (Month, Day, and Year)	
TIME OF DEATH (If known)		SIGNATURE OF DECEASED (If known)	
SIGNATURE OF WITNESS (If known)		SIGNATURE OF PHYSICIAN (If known)	
SIGNATURE OF CLERK (If known)		SIGNATURE OF JUDGE (If known)	



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE CLERK OF THE COUNTY OR CITY WHERE ISSUED. IT IS NOT VALID IF SIGNED BY ANY OTHER OFFICIAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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4204
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
64141
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Laurel)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Barbers Trailer Court</u>		d. STREET ADDRESS <u>Barbers Trailer Court</u>	
3. NAME OF DECEASED (Type or print) <u>Clavis Dail Smith</u>		4. DATE OF DEATH <u>April 2</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 2, 1905</u> 54 yrs.
9. AGE (In years last birthday) <u>54</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cash Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tapioca</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlottesville W Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Emmie Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>235-187059</u>	
17. INFORMANT <u>John Smith, Laurel, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>480X Infection</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Bronchial Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 days</u> <u>5 Mon-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> 19 <u>60</u> to <u>4/2</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>4/2</u> 19 <u>60</u> and that death occurred at <u>5AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		22d. ADDRESS <u>Laurel Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 4, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Charlottesville W. Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Donaldson, Laurel, Md</u>		25a. REC'D BY REGISTRAR <u>APR 8 '60</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Claudia L. Hines</u>	

STATE OF TEXAS
COUNTY OF DALLAS

1902

1

4205 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Glen Burnies	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 318 Milton Avenue		d. STREET ADDRESS 318 Milton Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marie Smith		4. DATE OF DEATH April 28, 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 22, 1907	
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Tudor		14. MOTHER'S MAIDEN NAME Sophie Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-4940	
17. INFORMANT Address Louis Smith-318 Milton Ave.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Metastatic carcinoma of lumbar spine left chest wall. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Duct cell carcinoma of left breast. (c) 5 months 5 years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 11 , 19 55 to April 28 , 19 60 that I last saw the deceased alive on April 27 , 19 60 , and that death occurred at 4:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 E. Chase Street DATE SIGNED April 28, 1960			
ACTUAL SIGNATURE Dwight M. Currie M.D.		DATE SIGNED April 28, 1960	
PHYSICIAN'S NAME (Type) Dwight M. Currie M.D.		Baltimore 2, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John C. Kelly Inc. - 2431 E. Olney St.		24a. REC'D BY REGISTRAR DATE 5/2/60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1-2 1-4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4156

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.					d. STREET ADDRESS 18 N. Woodlawn		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harry Middle Carl Last SORGNIT				4. DATE OF DEATH Month April Day 19 Year 1960			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-8-85	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY RETIRED			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME KARL SORGNIT				14. MOTHER'S MAIDEN NAME CHRISTINE HENNIGE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Son: Elwood C. Sorgnit		Address 309 N. Woodlawn Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis, Severe DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Nephrosclerosis, Generalized Arteriosclerosis							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Elmer G. Linhardt				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-19-60	
EXAMINER'S NAME (Type) Elmer G. Linhardt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 21, 1960		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland		24c. REC'D BY REGISTRAR DATE APR 22 '60	
				24b. REGISTRAR'S SIGNATURE Clayton L. Hanna			

MEDICAL CERTIFICATION

4208
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 Item 12-1110204 6-17-60 et

04144

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 25 c. LENGTH OF STAY IN 1b 60 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Baltimore (-25)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 416 E. Seward Ave.		d. STREET ADDRESS 416 E. Seward Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Josefa (Josephine) Sramek		4. DATE OF DEATH Month Day Year April 23, 1960 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1878
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 2 years	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Czechoslovakia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. Pacholik		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1	
17. INFORMANT Mrs. Harry Garreis, 416 E. Seward Ave.		Address 416 E. Seward Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V. disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to April 22, 1960 , that (I) (we) last saw the deceased alive on April 22, 1960 , and that death occurred at 8:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Sidney R. Gehlert		22b. DATE SIGNED APR 29 '60	
22c. PHYSICIAN'S NAME (Type) SIDNEY R. GEHLERT		22d. ADDRESS 4700 Perryman Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 26, 1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce, 4001 Ritchie Hwy., (25)		25a. REC'D BY REGISTRAR DATE APR 29 '60	
25b. REGISTRAR'S SIGNATURE Orin S. Kraus			

1211

RECEIVED

1211



P.D. 1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel Race Track		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 331 Frederick St. Cumberland, Md.			
3. NAME OF DECEASED (Type or print) First EARL Middle C. Last TAYLOR		4. DATE OF DEATH Month April Day 30 Year 19 60		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 32 yrs.		9. AGE (In years last birthday) 32
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laurel Race Track		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Taylor			
14. MOTHER'S MAIDEN NAME Edith Hollingsworth		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.			
16. SOCIAL SECURITY NO. 218-24-8233		17. INFORMANT Mrs. Edith H. Taylor			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral Injury DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 812X DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) pedestrian struck by auto			
20c. TIME OF INJURY Month, Day, Year Hour e.m. April 30, 60 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) racetrack	
20f. (City or town) Laurel		20g. (County) Anne Arundel		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3-1960		22c. NAME OF CEMETERY OR CREMATORY Woodlawn	
22d. LOCATION (City, town, or country) Cumberland Maryland		23. FUNERAL DIRECTOR Hager Funeral Service			
ADDRESS Cumberland Md.		24a. REC'D BY REGISTRAR MAY 3 '60		24b. REGISTRAR'S SIGNATURE Robert Murphy	

THE STATE
DEPARTMENT
M

1

RECEIVED
JUL 10 1950
U.S. DEPT. OF STATE

WILLIAM B. ROSTER

MAY 3 1950

April 30, 1950
Lester James Randall, Jr.

Washington, D.C.

4208

CERTIFICATE OF DEATH

Reg. Dist. No.

64147

1. PLACE OF DEATH a. COUNTY <u>Al</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Al</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Marys</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Marys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. Marys R. 7 D.</u>				e. STREET ADDRESS <u>St. Marys R. 7 D.</u>			
3. NAME OF DECEASED (Type or print) <u>Wathen Strong Tyler</u>				4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4th 1895</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Westwood N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Conrad M. Strong</u>				14. MOTHER'S MAIDEN NAME <u>Frances Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>George L. Tyler</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute myocardial infarction.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. m.</u> p. m. <u>19</u>	Month <u>4</u>	Day <u>2</u>	Year <u>1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/2</u> , 19 <u>60</u> , to <u>4/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:02</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Bedeman</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral</u>		DATE SIGNED <u>4/2/60</u>	
PHYSICIAN'S NAME (Type) <u>Conrad M. Strong</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr-5-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Winchester Va</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4157 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AA General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Ellen Last Wagner		4. DATE OF DEATH Month April Day 25 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/16
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 43 Days 43 Hours 43 Min.	11. IF UNDER 24 HRS. Months 43 Days 43 Hours 43 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Glen Burnie, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Harding		14. MOTHER'S MAIDEN NAME Lilly Ruby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-20-8857	
17. INFORMANT Mr. Thomas Wagner, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL HEMORRHAGE DUE TO (b) METASTATIC MELANOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 2 mos.	
21. I certify that I attended the deceased from 7-12 , 19 55 , to 4-25 , 19 60 , that I lost saw the deceased alive on 4-25 , 19 60 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 201 B & A Blvd. NW, Glen Burnie	
ACTUAL SIGNATURE Leon C. Perry		DATE SIGNED 4-26-60	
PHYSICIAN'S NAME (Type) Leon C. Perry, M.D.		22. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29/60	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		24. REC'D BY REGISTRAR APR 29 '60	
25. REGISTRAR'S SIGNATURE Arthur S. Kraus		26. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 10 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF MENTAL HEALTH
DIVISION OF HOSPITALS AND CLINICS
WASHINGTON, D.C. 20012

DATE: 6-10-64

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: JAMES EARL RAY

RE: NEW YORK TELETYPE TO BUREAU, 6-10-64

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE INFORMATION RECEIVED FROM THE NEW YORK OFFICE:

ON 6-10-64, THE NEW YORK OFFICE RECEIVED A TELEPHONE CALL FROM AN INDIVIDUAL WHO IDENTIFIED HIMSELF AS A MEMBER OF THE BLACK PANTHER PARTY (BPP).

THE INDIVIDUAL STATED THAT HE HAD INFORMATION CONCERNING THE WHEREABOUTS OF JAMES EARL RAY, WHO IS CURRENTLY A FUGITIVE FROM THE LAW.

THE INDIVIDUAL OFFERED TO ASSIST THE FBI IN LOCATING RAY, BUT REQUESTED A FEE OF \$10,000 IN ADVANCE.

THE NEW YORK OFFICE IS CURRENTLY ATTEMPTING TO VERIFY THE CREDIBILITY OF THE INDIVIDUAL AND HIS OFFER.

THE BUREAU IS REQUESTED TO ADVISE THE NEW YORK OFFICE OF ANY DEVELOPMENTS THAT MAY BE OF ASSISTANCE IN THIS MATTER.

VERY TRULY YOURS,

J. Edgar Hoover

Enclosure

1-11-64

1-11-64

1-11-64

1-11-64

1-11-64

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 64149

4158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>69 West Street</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>69 West Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Eckard</u> Middle <u>W.</u> Last <u>Walton</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 60</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1906</u> <u>Jan. 8, 1906</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House painting (self employed)</u>		11. BIRTHPLACE (State or foreign country) <u>Bristol</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Walton</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Markus</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW II</u> <u>215 12 4298</u>		17. INFORMANT Address <u>319 West Street</u> <u>Mrs. Clara Greenwell- Sister- Annapolis, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cardiac Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (c), stating the underlying cause lost. DUE TO <u> </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u> M.D. EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>April 4, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hoppring Funeral Home</u> <u>Annapolis, Md.</u>					24a. REC'D BY REGISTRAR <u>DATE APR 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>		

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ANNAPOLIS
CERTIFICATE OF DEATH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

64150

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mildred Middle Dove Last WAYSON				4. DATE OF DEATH Month April Day 7 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 11, 1875	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min.		IF UNDER 24 HRS. Months 85 Days 85 Hours 85 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME FRANKLIN DOVE				14. MOTHER'S MAIDEN NAME ALICE HUMPHREY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT MRS NORMAN SHEPHERD				Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute myocardial infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO 64a (c) DUE TO 64a							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 4, 1960 to April 7, 1960 , that (I) (we) last saw the deceased alive on April 7, 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Richard N. Peeler				22b. DATE SIGNED 4/7/60		22c. PHYSICIAN'S NAME (Type) Richard N. Peeler	
22d. ADDRESS 121 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		4-9-1960		Mt Zion Cemetery		Mt Zion Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sr				25a. REC'D BY REGISTRAR DATE APR 12 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

1138

422.2

MISS NORMAN SHEPHERD
JANICE HENDERSON

MISS NORMAN SHEPHERD

MISS NORMAN SHEPHERD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
4160
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
64151
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY AA					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville, Maryland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Lawrence Last White				4. DATE OF DEATH Month April Day 1 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1960			
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min. 5		11. BIRTHPLACE (State or foreign country) Annapolis Md		12. CITIZEN OF WHAT COUNTRY? U.S.A			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Annapolis Md			
13. FATHER'S NAME Oscar Sylvester White				14. MOTHER'S MAIDEN NAME Veronica Ann Holidayske					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Oscar S. White		Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Transposition of great vessels (c) 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2								INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-27 19 60 to 4-1 19 60 that (I) (we) last saw the deceased alive on 4-1 19 60 and that death occurred at 3:25 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Clayton Norton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-3-60			
22c. PHYSICIAN'S NAME (Type) Clayton Norton				22d. ADDRESS Severna Park, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr 4th 1960		23c. NAME OF CEMETERY OR CREMATORY St Marys Cent		23d. LOCATION (City, town, or county) (State) Annapolis Md			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				ADDRESS Annapolis Md		25a. REC'D BY REGISTRAR APR 6 '60			
						25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

2063233XV5

DEPARTMENT OF HEALTH
CENTRAL BUREAU OF VITALS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1175 West Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ver-non</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1917</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Troy, N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harley Williams</u>	
14. MOTHER'S MAIDEN NAME <u>Nan Harried</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Jack Williams - Annapolis, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> DUE TO (b) <u>Epilepsy</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3-5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4/4/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-9-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Besgate, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annap. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fines</u>			

MEDICAL CERTIFICATION

153

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

X 800

Form with multiple sections for medical examination and death certification, including checkboxes for various conditions and a signature line.

1. CAUSE OF DEATH (Immediate Cause)

2. CAUSE OF DEATH (Underlying Cause)

3. MANNER OF DEATH

4. MEDICAL HISTORY

5. PHYSICAL EXAMINATION

6. LABORATORY EXAMINATIONS

7. SIGNATURE OF MEDICAL EXAMINER

8. SIGNATURE OF WITNESSES

9. SIGNATURE OF CORONER

10. SIGNATURE OF JURY

11. SIGNATURE OF DISTRICT ATTORNEY

12. SIGNATURE OF CLERK

13. SIGNATURE OF SHERIFF

14. SIGNATURE OF JAILER

15. SIGNATURE OF PRISON WARDEN

16. SIGNATURE OF CHIEF OF POLICE

17. SIGNATURE OF CHIEF OF FIRE DEPARTMENT

18. SIGNATURE OF CHIEF OF SANITARY DEPARTMENT

19. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT

20. SIGNATURE OF CHIEF OF MENTAL HOSPITAL

21. SIGNATURE OF CHIEF OF EYE HOSPITAL

22. SIGNATURE OF CHIEF OF EAR, NOSE AND THROAT HOSPITAL

23. SIGNATURE OF CHIEF OF DENTAL HOSPITAL

24. SIGNATURE OF CHIEF OF DISPENSARY

25. SIGNATURE OF CHIEF OF PHARMACY

26. SIGNATURE OF CHIEF OF LABORATORY

27. SIGNATURE OF CHIEF OF X-RAY DEPARTMENT

28. SIGNATURE OF CHIEF OF PATHOLOGY DEPARTMENT

29. SIGNATURE OF CHIEF OF BACTERIOLOGY DEPARTMENT

30. SIGNATURE OF CHIEF OF CHEMISTRY DEPARTMENT

31. SIGNATURE OF CHIEF OF PHYSIOLOGY DEPARTMENT

32. SIGNATURE OF CHIEF OF ANATOMY DEPARTMENT

33. SIGNATURE OF CHIEF OF SURGERY DEPARTMENT

34. SIGNATURE OF CHIEF OF MEDICINE DEPARTMENT

35. SIGNATURE OF CHIEF OF OBSTETRICS DEPARTMENT

36. SIGNATURE OF CHIEF OF PEDIATRICS DEPARTMENT

37. SIGNATURE OF CHIEF OF PSYCHIATRY DEPARTMENT

38. SIGNATURE OF CHIEF OF RADIOLOGY DEPARTMENT

39. SIGNATURE OF CHIEF OF ELECTRICITY DEPARTMENT

40. SIGNATURE OF CHIEF OF MECHANICS DEPARTMENT

41. SIGNATURE OF CHIEF OF ARTS AND CRAFTS DEPARTMENT

42. SIGNATURE OF CHIEF OF MUSIC DEPARTMENT

43. SIGNATURE OF CHIEF OF THEATRE DEPARTMENT

44. SIGNATURE OF CHIEF OF SPORTS DEPARTMENT

45. SIGNATURE OF CHIEF OF GARDENING DEPARTMENT

46. SIGNATURE OF CHIEF OF FISHING DEPARTMENT

47. SIGNATURE OF CHIEF OF HUNTING DEPARTMENT

48. SIGNATURE OF CHIEF OF TRAVEL DEPARTMENT

49. SIGNATURE OF CHIEF OF TRANSPORTATION DEPARTMENT

50. SIGNATURE OF CHIEF OF COMMUNICATIONS DEPARTMENT

51. SIGNATURE OF CHIEF OF POSTAL DEPARTMENT

52. SIGNATURE OF CHIEF OF TELEGRAPH DEPARTMENT

53. SIGNATURE OF CHIEF OF TELEPHONE DEPARTMENT

54. SIGNATURE OF CHIEF OF RAILROAD DEPARTMENT

55. SIGNATURE OF CHIEF OF AIRCRAFT DEPARTMENT

56. SIGNATURE OF CHIEF OF NAVY DEPARTMENT

57. SIGNATURE OF CHIEF OF ARMY DEPARTMENT

58. SIGNATURE OF CHIEF OF MARINE DEPARTMENT

59. SIGNATURE OF CHIEF OF COAST GUARD DEPARTMENT

60. SIGNATURE OF CHIEF OF CUSTOMS DEPARTMENT

61. SIGNATURE OF CHIEF OF IMMIGRATION DEPARTMENT

62. SIGNATURE OF CHIEF OF NATURALIZATION DEPARTMENT

63. SIGNATURE OF CHIEF OF CITIZENSHIP DEPARTMENT

64. SIGNATURE OF CHIEF OF VOTER REGISTRATION DEPARTMENT

65. SIGNATURE OF CHIEF OF ELECTIONS DEPARTMENT

66. SIGNATURE OF CHIEF OF PUBLIC WORKS DEPARTMENT

67. SIGNATURE OF CHIEF OF STREET DEPARTMENT

68. SIGNATURE OF CHIEF OF PARKS DEPARTMENT

69. SIGNATURE OF CHIEF OF RECREATION DEPARTMENT

70. SIGNATURE OF CHIEF OF CULTURE DEPARTMENT

71. SIGNATURE OF CHIEF OF ARTS DEPARTMENT

72. SIGNATURE OF CHIEF OF LITERATURE DEPARTMENT

73. SIGNATURE OF CHIEF OF MUSIC DEPARTMENT

74. SIGNATURE OF CHIEF OF THEATRE DEPARTMENT

75. SIGNATURE OF CHIEF OF SPORTS DEPARTMENT

76. SIGNATURE OF CHIEF OF GARDENING DEPARTMENT

77. SIGNATURE OF CHIEF OF FISHING DEPARTMENT

78. SIGNATURE OF CHIEF OF HUNTING DEPARTMENT

79. SIGNATURE OF CHIEF OF TRAVEL DEPARTMENT

80. SIGNATURE OF CHIEF OF TRANSPORTATION DEPARTMENT

81. SIGNATURE OF CHIEF OF COMMUNICATIONS DEPARTMENT

82. SIGNATURE OF CHIEF OF POSTAL DEPARTMENT

83. SIGNATURE OF CHIEF OF TELEGRAPH DEPARTMENT

84. SIGNATURE OF CHIEF OF TELEPHONE DEPARTMENT

85. SIGNATURE OF CHIEF OF RAILROAD DEPARTMENT

86. SIGNATURE OF CHIEF OF AIRCRAFT DEPARTMENT

87. SIGNATURE OF CHIEF OF NAVY DEPARTMENT

88. SIGNATURE OF CHIEF OF ARMY DEPARTMENT

89. SIGNATURE OF CHIEF OF MARINE DEPARTMENT

90. SIGNATURE OF CHIEF OF COAST GUARD DEPARTMENT

91. SIGNATURE OF CHIEF OF CUSTOMS DEPARTMENT

92. SIGNATURE OF CHIEF OF IMMIGRATION DEPARTMENT

93. SIGNATURE OF CHIEF OF NATURALIZATION DEPARTMENT

94. SIGNATURE OF CHIEF OF CITIZENSHIP DEPARTMENT

95. SIGNATURE OF CHIEF OF VOTER REGISTRATION DEPARTMENT

96. SIGNATURE OF CHIEF OF ELECTIONS DEPARTMENT

97. SIGNATURE OF CHIEF OF PUBLIC WORKS DEPARTMENT

98. SIGNATURE OF CHIEF OF STREET DEPARTMENT

99. SIGNATURE OF CHIEF OF PARKS DEPARTMENT

100. SIGNATURE OF CHIEF OF RECREATION DEPARTMENT

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4209 CERTIFICATE OF DEATH

64153

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN lb 6 yrs. 1mo. 23 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				d. STREET ADDRESS 312 Howard Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Estella Middle Willis Last Willis				4. DATE OF DEATH Month 4 Day 28 Year 19 60				5. SEX Female				6. COLOR OR RACE Negro				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH December 12, 1890				9. AGE (In years last birthday) 69				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Dennis Jones				14. MOTHER'S MAIDEN NAME Florence Ford				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records				Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Decubital Ulcers DUE TO (c) Arteriosclerotic Hypertensive Cardiovascular disease																INTERVAL BETWEEN ONSET AND DEATH																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----																																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19				20d. INJURY OCCURRED While ----- of work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) -----				20f. (City or town) (County) (State)																											
21. I certify that (I) (this hospital) attended the deceased from 3/5 19 54 to 4/28 19 60 , that (I) (we) last saw the deceased alive on 4/28 19 60 , and that death occurred at 3:55 A. M. from the causes and on the date stated above.																																							
22a. SIGNATURE Hildegard Heard Reissman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 4/28/60																															
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland																																			
23a. (BURIAL/CREMATION, REMOVAL) (Specify) 4/30/60				23b. DATE THEREOF 4/30/60				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cumberland Md				23d. LOCATION (City, town, or county) (State) md																											
24. FUNERAL DIRECTOR'S SIGNATURE Water-Super Service				ADDRESS Cumberland Md				25a. REC'D BY REGISTRAR DATE MAY 2 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus																											

1110

STATE OF TEXAS
COUNTY OF DALLAS

IN SENATE

COMMITTEE ON

CHIEF CLERK

SECTION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64154

4210

1. PLACE OF DEATH a. COUNTY MARYLAND Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Pasadena				c. LENGTH OF STAY IN lb 20 hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) On the pier extending from the home of Mr. E. Voss, BaySide Beach.				d. STREET ADDRESS 5207 Carroll Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John Carlton Willis				4. DATE OF DEATH Month April Day 23rd Year 1960 19			
5. SEX M.		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/23/17	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk				10b. KIND OF BUSINESS OR INDUSTRY Wachapreague, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Willis				14. MOTHER'S MAIDEN NAME Minnie Richardson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Navy 1940-45				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mary Willis, (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO							INTERVAL BETWEEN ONSET AND DEATH Sydden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert, MD.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, MD.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/23/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 Apr., 60		22c. NAME OF CEMETERY OR CREMATORY Wachapreague Cemetery		22d. LOCATION (City, town, or county) (State) Wachapreague, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & KIRKREY, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE APR 26 '60		24b. REGISTRAR'S SIGNATURE Gail S. King	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
4211
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64155

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ST. MARY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRONNSVILLE</u>				c. LENGTH OF STAY IN 1b <u>5/2/49</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHARLOTTE HALL</u> <u>18X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CRONNSVILLE STATE HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>WILLIS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/1882</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co., MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES H. HOLBY</u>				14. MOTHER'S MAIDEN NAME <u>GEORGIANNA SLYE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL DEGENERATION</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME ASS. WITH CEREBRAL ARTERIO SCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from <u>7/2/1919</u> to <u>7/24/60</u> 19 <u>60</u> , that it (we) last saw the deceased alive on <u>4/2/60</u> , and that death occurred at <u>7:10</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				22d. ADDRESS <u>CRONNSVILLE STATE HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>		23d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

1

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Occupation		Cause of Death	
Date of Burial		Place of Burial	
Signature of Physician		Signature of Witness	
Signature of Coroner		Signature of Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4212 CERTIFICATE OF DEATH

64156

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> <u>Rt. 1, Millersville P.O.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park, Rt. 1, Millersville P. O.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Benfield Rd.</u>				d. STREET ADDRESS <u>Benfield Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edmund</u>		First <u>White</u>		Middle <u>Winchester</u>		Last	
4. DATE OF DEATH <u>April</u>		Month <u>17</u>		Day <u>19</u>		Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul. 15, 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd. Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Playground Equipment Md.</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Pere Winchester</u>				14. MOTHER'S MAIDEN NAME <u>Kattie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Edmund W. Winchester</u>		Address <u>Box 395 D, Route 1</u> <u>Millersville P.O. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO <u>1. Hypertensive Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>2. Arteriosclerosis, generalized.</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> 19 <u>59</u> to <u>April</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Feb.</u> 19 <u>60</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis I. Codd</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-13-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd</u>		22d. ADDRESS <u>Severna Park, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons - Balt</u>				25a. REC'D BY REGISTRAR DATE <u>APR 18 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

420

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4162

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64157

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lola</i> Middle <i>Jane</i> Last <i>Worth</i>		4. DATE OF DEATH Month <i>4</i> Day <i>29</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 13 - 1960</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Clyde B. Worth</i>		14. MOTHER'S MAIDEN NAME <i>Pattie Lee Winn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Clyde B. Worth</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>924.0</i> DUE TO <i>Cisphyxia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Subar (Plastic) feed over infant's face</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>8</i> a. m. <i>4:29</i> p. m. <i>1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Annapolis AA MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 2 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Spring Lawn Cem</i>		22d. LOCATION (City, town, or county) (State) <i>New Paris Ohio</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 2 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>			

2040203XV5

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>Washington, D.C.</i>		5. OCCUPATION <i>Teacher</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. DATE OF DEATH <i>Jan 15, 1918</i>		8. TIME OF DEATH <i>10:30 AM</i>		9. PLACE OF DEATH <i>Home</i>	
10. SIGNATURE OF MEDICAL EXAMINER <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

VS. A1SME
AM 7/59

3
M
4158
4163
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park		
c. LENGTH OF STAY IN 1b DOA 05.			d. STREET ADDRESS Manhattan Beach		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital					
3. NAME OF DECEASED (Type or print) Blanche			4. DATE OF DEATH Month April Day 18 Year 1960		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2/12/60		9. AGE (In years last birthday) yrs. 2 Months 6 Days		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James E. Young			
14. MOTHER'S MAIDEN NAME Martha Ann Jones		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Address James E. Young, Same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis DUE TO 472X Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.		DATE SIGNED April 19, 1960	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Glen Burnie, Md.	
22d. LOCATION (City, town, or country)		(State)			
23. FUNERAL DIRECTOR Hopping and Kirkley		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE APR 22 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Petty					

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